HOSPITAL ABSTRACTS

A MONTHLY SURVEY OF WORLD LITERATURE

PREPARED BY THE DEPARTMENT OF HEALTH

AND SOCIAL SECURITY

VOLUME 15, NO. 5, ABSTRACTS 609-760. MAY 1975

LONDON: HER MAJESTY'S STATIONERY OFFICE

85p net

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First published 1975

ISBN 0 11 722485 5

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HOSPITAL ABSTRACTS

Vol. 15 May 1975 No. 5

HOSPITALS IN GENERAL

609. McGILL, C. S. **A look into the hospital of the future.** *Trustee*, Chicago, 1974, Dec., vol. 27, no. 12, pp. 14-20.

This paper predicts that the hospital will expand in the future to become a complex medical centre, and describes the changes in organization and administration which will necessarily be involved in this change. Topics covered include: (i) the structure of the governing board; (ii) medical staff structure; (iii) cost containment efforts; and (iv) quality assurance and peer standards review organizations.

HOSPITALS IN GREAT BRITAIN

See Abstract No. 610

HOSPITALS IN OTHER COUNTRIES

610. MAYNARD, A. **Hospital care in Britain and France.** *Hospital and Health Services Review*, London, 1975, Feb., vol. 71, no. 2, pp. 50-53.

The provision of hospital care in France is discussed and its characteristics are compared with those of England and Wales. In 1972, of 533,500 hospital beds in France (10.39 per 1,000 population) 30 per cent were owned by private establishments. Private provision of psychiatric beds is small (8.5 per cent). Private hospitals may be either profit- or non-profit-making. The former, owned by groups of individuals or companies, tend to be in the more affluent areas of France. They usually have about 50 beds whereas the non-profit ones have an average of 100 beds. There are 902 general public hospitals, 28 of which are regional hospital centres with an average of 3,189 beds, 99 are hospital centres (average 633 beds), 404 hospitals (average 175 beds) and 371 rural hospitals (average 31 beds). Length of stay in France averages 15.7 days compared with 10.4 in the United Kingdom. Over 90 per cent of the income of French public hospitals comes from fees charged to patients; direct state subsidies are small. Labour is the largest item of expenditure (60 per cent). Geographical inequalities are common to both countries: a table in the text shows the distribution by regions in France. Recent legislation aims at developing more equal provision and providing a comprehensive system for diagnosis and treatment.

611. BAUER, W. Die wichtigsten Gegenwartsprobleme unserer Krankenhäuser. **[The most important current problems of our hospitals.]** *Krankenhaus*, Stuttgart, 1975, Jan., vol. 67, no. 1, pp. 1-6, 8.

This is a general survey, by the president of the German Hospital Association, of some of the most important current problems of German hospitals. Among the

subjects discussed are the following: the danger of 'levelling down' hospital services; hospital finance as affected by recent legislation; the fixing of the cost per patient day; general measures aimed at reducing costs; staffing complements and staff shortages; and payment and contracts of senior medical staff.

612. FOCKE, K. Das Krankenhaus heute und morgen. **[The hospital today and tomorrow.]** *Krankenhaus*, Stuttgart, 1975, Jan., vol. 67, no. 1, pp. 15-19.

This is the address given by the West German Federal Minister for Youth, Family and Health on the occasion of the silver jubilee of the German Hospital Association in 1974. The following points were among those she made: the hospital is, and must remain, a place of help and human relationship; hospitals are labour-intensive undertakings which require a high degree of expert and humane responsibility and where team work is especially necessary; even hospitals must be limited by existing financial resources; hospitals are modern undertakings which must be run economically and efficiently; and as a part of the health service hospitals must, both for the benefit of patients and the whole health system, accept the need for rational planning and co-operation.

613. PAKUŁA, W. and GIERSZ, B. Organizacja i działalnosc Zespołu Opieki Zdrowotnej w Mysłowicach wokresie 1 I 1972—30 IX 1973 R. **[The organization and activities of Mysłowice Health Care Complex, 1 January 1972 to 30 September 1973.]** *Szpitalnictwo Polskie*, Warszawa, 1974, July/Aug., vol. 18, no. 4, pp. 177-180; summaries in Russian and English pp. 180-181.

On 1 January 1972 two hospitals, all out-patient services and the district ambulance service in Mysłowice were merged into the Mysłowice Health Care Complex. This paper describes the process of this functional integration. Centralization of administration, laboratories, diagnostic X-ray departments, stores, transport and finance resulted in more rational, efficient and economical use of services. Doctors in charge of specialties are responsible for the proper allocation of staff and equipment. This has resulted in more comprehensive care, improved quality of care, alleviation of staffing problems and easier admissions. In 1973 all nurseries, a children's home and a welfare home were added to the complex; this presented some advantages and many disadvantages. The scheme has proved that integrated health services provide better therapeutic facilities and improved use of available resources.

PLANNING, DESIGN AND CONSTRUCTION

See also Abstract Nos. 717, 718, 729

614. PERSSON, E. Planering av ett modernt sjukhus. **[Planning a new hospital.]** *Landstingens Tidskrift*, Stockholm, 1975, Feb., vol. 62, no. 2, pp. 46-51.

The general plan (design, ward structure, size, etc.) for the new Helsingborg Hospital was decided in 1967, and divided into the following stages: (i) detailed architectural planning; (ii) departmental function planning; (iii) room function

programming; (iv) operational planning; (v) take-over plan; and (vi) running-in and follow-up. Stage (ii) ensured a smooth flow of people and materials, and short lines of communication. The work of planning room function took 18 months and included work routines, floor space requirements, widths of doorways, and acoustic, lighting, radiation-shielding, ventilation, humidity and equipment requirements. Operational planning covered organization, accommodation, apparatus and services, and main tasks in the various departments. The planning staff were divided into five working parties, with responsibility for: (i) financial control; (ii) programming and planning; (iii) equipment; (iv) staffing and training; and (v) forward planning. Since the main burden fell on group (ii), it was sub-divided into working parties for internal service functions, medical production and nursing productivity (the production of 'care'). In addition to the three diagrams illustrating three of the six planning stages, there are three external and five internal photographs of the new hospital.

615. ADAMS, M. A. **Planning with particular reference to isolation units.** *Nursing Times*, London, 1975, Feb. 13, vol. 71, no. 7, ICNA supplement pp. 12-13.

Each hospital district should have a separate isolation unit rather than a number of such beds attached to different specialties. The recommended number of beds for such a unit is 20 and at present the cost allowance is £120,000 and the total permitted area is 706 sq.m. unless, in a special case, permission is given to exceed this limit. The six planning stages of a hospital are described with special reference to the requirements of an isolation unit.

SELECTION OF SITE

616. CAETANO, E. **Hospital sites.** *Hospital Engineering*, Stevenage, 1975, Jan./Feb., vol. 29, pp. 24-28; summaries in French, German and Italian p. 28.

The author's views on the siting of hospitals are illustrated by experience and examples from Portugal, particularly the Lisbon area. The main factors to be considered are the following: accessibility (the preferred areas in a city are on the periphery or in the inner suburbs); the environment; the neighbouring amenities; the direction of the prevailing winds; the space available (adequate for existing needs and possible future expansion); and the need for protection zones (patients must be protected from smoke, dust, noise, vibrations, and outside infringement of privacy).

BUILDING: TENDERING, ETC.

617. CLARK, S. **As designer and contractor you can cut costs.** *Hospital Administration in Canada*, Don Mills, Ont., 1975, Jan., vol. 17, no. 1, pp. 38-39.

The author, who is director of building services at Wellesley Hospital, Toronto, describes how he has taken over entire responsibility for building projects within the $20,000 to $60,000 price range. At the hospital he is in charge of maintenance and the power plant as well as projects—he spends less than a third of his time on the latter. Examples of projects successfully completed, in which he acted both as

designer and contractor, are a small health centre and alterations to the emergency and admitting departments: another scheme, the renovation of a family practice clinic, is at the design stage. The author is convinced that the advantages of the system, which include cost reductions, outweigh the disadvantages. It is important however that too much is not attempted or other duties will suffer.

HOSPITAL DESIGN

618. VALENTINE, B. H. and EVERS, F. **A medical centre design plan.** *Journal of the Royal Army Medical Corps*, London, 1975, Jan., vol. 121, no. 1, pp. 29-33.

The plan described incorporates the usual requirements of a medical centre with the addition of short-stay or recuperative beds which would be under the attendance of a general practitioner. An investigation of all the requirements indicated that only a circular building would give the mobility and variability needed whilst having the least drawbacks. Concrete foundations holding a steel structural framework or cast concrete framework would be used. Prefabricated elements, including standard sized windows and doors, could be fitted on to the basic frame on site. The centralized design gives fluidity of movement and lends itself to decentralization in areas where congestion is undesirable. It is extremely functional in terms of staff mileage and reduces wasted floor space. One disadvantage is that room sizes are standard modules which makes it difficult to alter them when one is dealing with pre-constructed floor areas incorporating underfloor heating. This form of central heating would be very economical used in conjunction with double glazing and roof insulation. The hypothetical plan was conceived on a floor space of 270 sq.m. which included first floor balconies. The total cubic content was about 1,623 cu.m. Modifications of the basic design are possible including a third floor if required. Floor plans and a drawing of the proposed centre are given.

DESIGN OF INDIVIDUAL GENERAL HOSPITALS

See also Abstract No. 614

619. **Addition, renovation reorganize hospital complex.** *Hospitals*, Chicago, 1975, Jan. 16, vol. 49, no. 2, pp. 23, 26.

An expansion of Poudre Valley Memorial Hospital, Fort Collins, Colo., accommodated irregular forms and uneven levels in the existing buildings, allowed all departments to remain in operation during reconstruction, and allowed remodelling of relocated departments after reconstruction. The existing building was an H-shaped complex in which a 2½-storey building was connected to the original three-storey building. The new addition was built to the south of the existing complex, abutting the bottom part of the H. The new building accommodates 20 private and nine double patients' rooms per ward floor. On each floor the nurses' station is located in a central core, and utility rooms, classrooms and other supporting services are located at the ends of the core. Also included are the entrance hall, offices, classrooms, coffee bar, intensive and coronary care unit, new surgery, radiology and pathology departments, kitchen, dining-room, central supply and pharmacy.

620. **New general hospital at Kilton.** *Hospital Development*, London, 1975, Jan./Feb., vol. 3, no. 1, pp. 12-15.

A new general hospital (consulting architects: Charles B. Pearson, Son and Partners) is to be built on the site of the existing Kilton Hospital, Worksop, Nottinghamshire. It will serve a population of 120,000 in Worksop and Retford and is to be built in three phases the first of which is due to be started in late 1976 or early 1977: this will provide, among other things, the accident and emergency department, maternity clinic, operating theatres, X-ray department, intensive care units, beds and day places for psychiatric patients and mentally handicapped children, and an interim kitchen. Later phases will provide 272 acute and 84 geriatric beds, pharmacy, out-patient department, main kitchen, dining-rooms, stores, etc. During construction there will need to be some re-arrangement of services at the existing Kilton and Victoria Hospitals. A site plan and some artists' impressions are included.

DESIGN OF SPECIAL DEPARTMENTS

621. BEAVAN, A. J. **Design for health service catering.** *Hospital Development*, London, 1975, Jan./Feb., vol. 3, no. 1, pp. 18, 20-21.

When kitchens are being planned the services of the regional catering officer, who will have had wider experience, should be enlisted to supplement the advice of the hospital's own catering staff. Although there has been a tendency to site kitchens on the top floor they are most conveniently placed on the ground floor adjoining the staff restaurant. Catering services of district general hospitals could also cover community hospitals, day centres, community homes and meals-on-wheels: frozen meals could be sent out from a central preparation kitchen with cold dishes, salads and garnishing being prepared locally. If and when the use of frozen bulk-packed meals becomes common central kitchens can be suitably converted without much difficulty. New hospitals should install one of the various types of tray service.

DESIGN OF SPECIAL HOSPITALS OR UNITS

See also Abstract No. 750 (Children, Psychiatric)

622. JUTZI, A. Das Alters- und Pflegeheim Horn TG. **[Old people's and nursing home, Horn.]** *Hospitalis*, Zürich, 1975, Feb., vol. 45, no. 2, pp. 51-54.

The combined old people's home and long-stay nursing home at Horn (architects: Keller and Kappeler of Arbon) came into use in July 1974. It is a four-storey building arranged as follows: ground floor—dining room, kitchen, lounge, and two rooms for the physically handicapped; first floor—nursing home with one single and 10 double patients' rooms, each with wash-basin and toilet, and wide corridor and balcony which serve as day rooms; second and third floors—12 single old people's rooms on each floor, which can be combined where necessary for married couples: each has toilet, wash-basin and shower and each floor has a small kitchen and rooms for cleaning; fourth floor—staff rooms and terrace and additional day room for residents.

WARDS AND PATIENTS' ROOMS

623. HODGSON, H. **Patients and privacy.** *Hospital and Health Services Review*, London, 1975, Feb., vol. 71, no. 2, pp. 44-46.

The author, who is Vice-President of the Patients Association, believes that it should be possible to provide private rooms for all who want them by making economies in the health service and on expenditure generally. Two surveys carried out about 10 years ago showed that eight per cent and 11 per cent respectively of patients questioned wanted single rooms. The necessary figure for single rooms for all purposes might be around 28 to 31 per cent. It is suggested that the objection to single rooms is a question of prejudice rather than cost. Another objection to single rooms is that they need more nursing staff but the automation of services would help here and it is hoped that with better pay and conditions the shortage of nurses will be reduced. Advantages of single rooms include: (i) they help to reduce infection; (ii) they make a ward more flexible and could increase bed occupancy by eliminating restrictions imposed by sex, age and specialty; and (iii) they solve the problems of visiting, early waking, sleepless nights, noise and smoking. The amenities enjoyed by private patients, especially privacy, should be every patient's right. This right should be acknowledged in principle and every effort should be made to provide enough single rooms by adapting old hospitals where possible and by building them into new ones.

ENTRANCES, CORRIDORS AND STAIRWAYS

624. **Northwick Park Hospital: entrance.** *Interior Design*, Morden, 1975, March, pp. 146-147.

Immediately inside the main entrance to Northwick Park Hospital, where all patients and visitors arrive, there are two major alternative routes, to the main in-patient areas and to the out-patient department. The reception desk and information counter face the main entrance doors. The receptionist can easily indicate directions to enquirers and it is also a centre for the appointments system. The floor of the entrance hall is covered with a bronze Bri-nylon carpet; this is taken up the front of the information counter. On the hall alongside the counter is a linear design in two shades of yellow and blue on white. Special lighting is used to illuminate the counter and the wall decoration. The lettering and counter top are orange, the curved wall is white and the elevated data retrieval desk is covered in deep blue vinyl. A plan and three photographs are included.

ENGINEERING SERVICES

See Abstract No. 655

INSTALLATIONS IN GENERAL

625. OLFFEN, E. van. Nieuwbouw Rode Kruis Ziekenhuis te Beverwijk. **[New Red Cross Hospital, Beverwijk: heating and air-conditioning installation uses 112,000 cu.m. of air per hour.]** *Technische Gids voor Ziekenhuis en Instelling*, Amsterdam, 1975, Feb. 4, vol. 44, no. 1068, pp. 76-79.

The new 270-bed Red Cross Hospital at Beverwijk (architect: W. van Campen,

Amsterdam) completed at the end of 1973, has all technical installations on the top floor. These include heating, cooling and air-conditioning plant. This top floor is specially insulated and sprung so that undue noise and vibrations do not disturb lower floors. The two air-conditioning installations each have a capacity of 56,000 cu.m. per hour and, by means of window ledge units which are provided with heat exchangers, each room can regulate its own air-conditioning. The operating suite and cardiac unit, with 20 air changes per hour, are immediately below the top floor. The total heat capacity is 3,315,000 kcal/h. supplied by three boilers fired by natural gas. Details are given of the installations, including the fire control system, insulation, and temperature control and there are seven photographs of the installations.

HEATING

See Abstract No. 625

VENTILATION AND AIR-CONDITIONING

See Abstract No. 625

INSULATION AGAINST SOUND AND TEMPERATURE

See Abstract No. 699

EQUIPMENT, FITTINGS, FURNITURE

INTERIOR DECORATION

See also Abstract No. 624

626. SCHUM, M. L. **Mercy Health Center, Oklahoma City: humanizing a hospital interior.** *Hospital Progress*, St. Louis, 1975, Jan., vol. 56, no. 1, pp. 34-37.

The interior decoration at the Mercy Health Center, Oklahoma City, aims at providing an environment which is neither overstimulating nor depressing. The foyer has strong geometric patterns with deep brown and rust tones to recall the prairie locale and red and blue accents to recall the primary colours of the American Indians: there are murals of precast concrete. In patients' rooms colours are more restrained. Matching fabric of bedspread and upholstery have red, orange, gold, blue and brown tones. Walls and curtains are subdued enough to relax without boring the patient. More vivid colours and complex patterns are used in public areas: treatment areas are cheerful but not too stimulating. Carpeting—patterned because it is more pleasant to look at and less easily marked—is used in as many areas as possible.

627. **Dining areas, Western Infirmary, Glasgow.** *Interior Design*, Morden, 1975, March, p. 154.

The first phase of the reconstruction of the Western Infirmary, Glasgow, includes a 700-seat dining/coffee room. The greatly extended U-shaped area covers 11,000 square

feet. Its division, which was considered desirable because of its length, has been dictated to some extent by the plant rooms above and the location of the convection heating units. The decor generally makes bold use of strong colours in the red/orange range. The floor is covered in black and white vinyl tiles. Some details are given of the furniture and furnishings, which were selected with a view to obtaining the maximum comfort, durability and appeal available within the cost limits. Three photographs are included.

628. **High performance wall coating.** *Hospitals*, Chicago, 1975, Jan. 16, vol. 49, no. 2, pp. 85-86.

Selection of suitable wall coatings for the various areas within a hospital is a problem for administrators, supplies officers, architects and engineers. In the past, wherever heavy-duty performance was needed, ceramic tiles were used. However, high performance architectural coatings (HIPAC) give a similar performance to tiles at a fraction of the cost. HIPAC coatings maintain their appearance and usefulness three to five times longer than conventional paint coatings and yet can withstand heavy traffic, frequent cleaning and abuse. There are three basic types of HIPAC coatings: epoxy polyamide, epoxy polyester and polyurethane. Their characteristics are outlined.

FURNITURE AND FITTINGS IN GENERAL

629. **Hospital furnishing: a special supplement.** *Hospital Equipment & Supplies*, London, 1975, March, vol. 21, no. 3, pp. 31-50.

This supplement contains short papers on: home-from-home furnishing; landscaped offices; soft floor coverings; planning seating accommodation; flooring demands within hospitals; and paints. Brief details are given of a number of furniture products. The supplement also contains numerous photographs.

WARD FURNITURE, FITTINGS AND EQUIPMENT

630. ANDREWS, J. and ATKINSON, L. **Ward furniture and equipment in geriatric departments.** *Hospital Equipment & Supplies*, London, 1975, Feb., vol. 21, no. 2, pp. 29-31.

Providing suitable equipment for the physically handicapped, and particularly for the elderly handicapped, is necessary so as to help them to achieve their maximum physical potential in carrying out their day-to-day activities. Equipment is found under-used, misused or wrongly bought for a number of reasons. There is a great need for the establishment of a post for an occupational therapist or a nurse to be in charge of ward furniture/equipment in a geriatric department. The duties of the post are outlined. There is also an urgent need for a guide to geriatric ward equipment. Some of the issues involved are discussed and comments are made on some successful items, including chairs, beds and bed cradles. There is a need for more co-operation between designers and the geriatric team, adequate trials of equipment, and more thought on the procurement of adequate equipment.

631. KORESKA, J. and ALBISSER, A. M. **A new foam for support of the physically handicapped.** *Biomedical Engineering*, London, 1975, Feb., vol. 10, no. 2, pp. 56-58, 62.

A new urethane foam called Temper Foam was developed in 1971 and has been used in experimental support systems for the support of non-ambulant muscular dystrophy patients at the Hospital for Sick Children, Toronto. In this paper the more significant properties of this new material are described and explained in terms of its microstructure. When a patient sits on the foam the cells compress and air leaks from the cells of high pressure into areas of lower pressure until an equilibrium pressure is re-established. Because the material is visco-elastic in nature the pressure distribution tends to be uniform in spite of large surface irregularities characteristic of the load. Patients who could spend no more than three hours at a time in a standard wheelchair can spend over 10 hours continuously on the foam. Of 14 patients at present using the foam 10 have been using it for over 10 months. Usually such children show increasing signs of discomfort and skin breakdown but this has been avoided by the use of the foam support system. A table illustrates the mechanical properties of the foam and photographs show the microstructure.

632. NORTON, D. **The ergonomically-organised environment.** *Hospital Equipment & Supplies*, London, 1975, Feb., vol. 21, no. 2, pp. 40-42.

This paper emphasizes the need to provide an ergonomically-organized environment when physical disability is present, and particularly when strength, will or knowledge are decreasing in advanced old age. Furniture and equipment for geriatric nursing are therefore not to be regarded merely as inanimate objects with a function but as an extension of the nurse in her therapeutic role. The basic essentials for such an approach are outlined, with particular reference to bed-tables, chairs, beds, bedside locker/wardrobes, eating and drinking utensils and water closets.

ELECTRONIC EQUIPMENT

See Abstract Nos. 711, 714

STAFF GENERALLY

STAFF COMPLEMENTS

See also Abstract No. 642

633. HUGHES, A. D. **Manpower planning and training—an organisational dilemma.** *National Hospital*, Chippendale, N.S.W., 1974, Oct., vol. 18, no. 10, pp. 25-29.

The basic aim of manpower planning is to provide the staff to achieve the required objectives. There should first of all be clearly defined long-term goals: the next step is an accurate determination of existing manpower capabilities. The major decisions which determine the availability of manpower are in most cases made by governments

and educational institutions; exceptions are nursing and managerial and supervisory posts. Training in management involves a combination of professional study, in-service training, understudying and selective reading. Most hospitals do not have personnel departments but there should be a manpower planning and training officer.

RECRUITMENT

See Abstract No. 647

CONDITIONS OF SERVICE

634. WARNER, R. G. **New system for paid absences benefits hospital, staff.** *Hospitals*, Chicago, 1975, Jan. 16, vol. 49, no. 2, pp. 81-83.

Exeter (N.H.) Hospital has developed a new staff benefit package, Earned Time (ET), which replaces traditional vacation, statutory holiday and sick leave benefits with one category of time off with pay. Staff who previously had two weeks vacation now have 25 ET days per year (10 in lieu of vacation, nine in lieu of statutory holidays and six in lieu of sick leave); individuals who had three or four weeks vacation receive an additional five or 10 days ET per year. Details of the scheme are given and some problems of implementation are discussed. The hospital has not received any criticism of the programme and has not found that any hardship has been caused to any staff as a result of the plan. There has been a marked decrease in sick leave absences, allowing smoother functioning in the departments and removing a potential morale problem.

635. BURNS, J. B. **NHS salary evolution: survival of the fittest.** *Health and Social Service Journal*, London, 1975, March 8, vol. 85, no. 4429, pp. 544-546.

This paper analyses the changes in the salaries of the various groups of hospital staffs in Great Britain between 1955 and 1973. Those considered are administrative staff, medical staff, scientists, pharmacists, nurses and midwives, engineers, medical laboratory technicians, building supervisors, radiographers, and ancillary staff. Appraisal of the salary movement shows that strikes and demonstrations are not the most effective weapons in any salary war; those professions which have been the subject of a special report seem to have gained as much by other people's efforts. If health service employees are to become non-militant, then the negotiators on both sides must adjust pay according to some compatible yardstick such as the cost of living and should take account of increased work content and skills.

STAFF MANAGEMENT

See also Abstract Nos. 643, 672

636. CATANIA, J. J. **Employe counselor serves as ombudsman.** *Hospital Progress*, St. Louis, 1975, Jan., vol. 56, no. 1, pp. 60-61.

At the Crozer-Chester (Pa.) Medical Center, a professional guidance counsellor was appointed to advise and help the staff. Employees were told about the scheme

by individual letters from the hospital's president and for the first few months of service the counsellor was occupied with getting to know the hospital and its middle and top management. During the first year of actual operation of the counselling scheme 987 of the 1,114 full-time employees were interviewed: only six employees were not interested, the others not seen were absent through illness, leave or other special circumstances. Of those interviewed 88 per cent indicated positive reactions to their jobs and only 12 per cent said that they were unhappy. Every endeavour was made to help staff with their problems and questions were answered either during the interviews or were looked into and answered later. The scheme was gratifyingly successful and it is planned to expand it.

STAFF TRAINING

See also Abstract Nos. 633, 641, 644-650, 652, 655, 690, 752

637. GALLAGHER, J. C., MITCHELL, J. and GELSINGER, J. L. **Inservice education via telecomunications network.** *Hospitals*, Chicago, 1975, Jan. 16, vol. 49, no. 2, pp. 65-66, 70.

The telephone lecture network (TLN), initiated by the Lakes Area Regional Medical Program, provides continuing education programmes to hospitals and other health care institutions in seven counties in western New York and in two counties in north western Pennsylvania. This paper outlines the mechanics of TLN and describes the series of lectures developed for catering staff. Nineteen programmes, each lasting about 20 minutes, were prepared for the 1973-74 catering series; each concentrated on a single concept to ensure that the content would be more easily and completely retained. Each lecture is accompanied by 35 mm. slides.

638. SCHECHTER, D. S. **Agenda for continuing education: a challenge to health care institutions.** Chicago, Hospital Research and Educational Trust, 1974, xi, 112pp. $6.00

The Hospital Continuing Education Project was carried out from 1964 to 1972 with a grant from the W. K. Kellogg Foundation to the Hospital Research and Educational Trust. In this volume the director of the project discusses some of the needs which were identified and puts forward specific proposals for meeting them.

STAFF WELFARE

See also Abstract No. 712

639. HENDRICK, D. J. and LANE, D. J. **Formalin asthma in hospital staff.** *British Medical Journal*, London, 1975, March 15, vol. i, pp. 607-608.

This paper describes the use of inhalation provocation tests to investigate the relevance of inhaled formalin fumes to airways obstruction in two hospital staff members continually exposed to this substance in the course of their work. The suspected aetiological role of formalin was confirmed in one patient but excluded in the other. As a result measures of environmental control were introduced where appropriate, with good effect.

640. HOWELLS, C. H. L. **Infections in hospitals.** *Proceedings of the Royal Society of Medicine*, London, 1975, Feb., vol. 68, no. 2, pp. 95-97.

This paper outlines the incidence among staff at the University Hospital of Wales of, and/or the precautions necessary against, the following infections: *Staphylococcus aureus*, *Streptococcus pyogenes*, Gram-negative rods, Gram-positive rods, tuberculosis, hepatitis, herpetic whitlow, rubella, influenza and smallpox. At this hospital, infections occurred especially amongst those staff with no special knowledge and not trained in asepsis. Of the 273 housekeeping staff, 174 (63.7 per cent) presented 638 medical certificates between 1 October 1973 and 31 March 1974; well over half of this was caused by infections.

SPECIAL CLASSES OF STAFF

ADMINISTRATIVE AND CLERICAL STAFF

641. DAVIS, S. and HENSHAW, S. **Decision analysis in hospital administration: a tool for curriculum revision.** Washington, Association of University Programs in Health Administration, 1974, [iii], 26pp. $2.00

This report describes a project in which former students of the Graduate Program in Health Services Administration, School of Public Health, Columbia University, were encouraged by the school to investigate the role and function of hospital administration with the objective of making changes in the curriculum. The questionnaire used is reproduced and the results are presented in seven tables and discussed. The project identified areas of importance to hospital administration in which students of Columbia were not adequately prepared, it also identified areas in which they were being overtaught. The project has demonstrated the value of consulting former students and the need for a system that continually evaluates and updates a course of study.

MEDICAL STAFF

See Abstract Nos. 738-740

NURSING STAFF

See also Abstract Nos. 690, 743, 752, 753, 755

642. BROWN, A. A. **Assessing nursing manpower.** *National Hospital*, Chippendale, N.S.W., 1974, Oct., vol. 18, no. 10, pp. 19-23.

A computer-based nurse use study which has so far been carried out in three Australian hospitals by a research and management consultant organization is described. The main objectives are: to develop simple staffing guides for determining daily manpower requirements; to document nursing activities and analyse their distribution through the day; and to define the allocation of nursing skills and calculate staff levels. At one hospital a quality control survey provided a measured assessment in the form of a percentage of the quality of nursing care, based on observed and recorded facts. This gave a measurement of the quality of nursing care, revealed areas

where improvements were needed and provided guidelines for the future. Specimens of the forms used and of printouts are included.

643. STAPLES, S. and CURTIS, B. L. **Extended work day—two years later.** *Hospital Administration in Canada*, Don Mills, Ont., 1975, Jan., vol. 17, no. 1, pp. 32, 34.

In 1972 St. Paul's Hospital, Vancouver, introduced a longer working day for nurses. Instead of a 7½-hour day they worked 11½ hours for four days followed by five days off. With the current contract calling for a 37½-hour week this meant that nurses 'owed' 19 hours a year: this was made good by attendance for that number of hours, during off-periods, for formal training. An assessment after two years concludes that the quantity of patient care has increased. The nurses have benefited from increased leisure, but the amount of nurses' sick leave has increased if measured by hours (though it has decreased in terms of lost shifts). The Registered Nurses Association has given general approval to the extended working day.

644. BROWN, R. A. and TOWNSEND, I. **Educational technology in the school of nursing.** *Nursing Times*, London, 1975, Feb. 20, vol. 71, no. 8, pp. 316-317.

The 'learning resources centre' (LRC) uses every type of teaching resource from the highly sophisticated computer terminal to the simplest aids. Ideally it should be staffed by someone with experience in communication studies, educational technology, the theory and practice of education, and graphic design. Within schools of nursing the need for resource based learning is becoming clear and its use would fit in with the recommendations of the 1972 Report of the Committee on Nursing [see *Hospital Abstracts*, Vol. 13, Abstract 34]. An LRC should be established by involving as many staff and students as possible in analysing the content of the course, structuring material, establishing what has to be learnt and planning and producing learning packages.

645. HABESHAW, T. **New teaching methods in training clinical teachers.** *Nursing Times*, London, 1975, Feb. 20, vol. 71, no. 8, pp. 300-302.

The course for clinical nursing teachers at Bristol Polytechnic has recently been reorganized. The clinical teachers are taught by a variety of methods including individual tuition, group learning, tutorials, and closed-circuit television. In one exercise the class divides into groups of four or five to discuss a topic, each group being given a varying amount of information; they then reassemble to discuss together the conclusions reached. Clinical teachers are also called upon to give spontaneous answers to questions. The aim is to put the teachers in the position their students would be in so that they develop increasing sensitivity to their feelings and attitudes. The course members have proved to be highly successful in the Royal College of Nursing examinations.

646. HEZEKIAH, J. A. **An experiment with the ladder concept.** *Canadian Nurse*, Ottawa, 1975, Jan., vol. 71, no. 1, pp. 20-22.

In 1972 the Humber College of Applied Arts and Technology, Rexdale, Ont., inaugurated a common initial semester for nursing diploma and nursing assistant students. The course, for both groups, included bioscience, developmental psychology,

sociology, community health, nursing theory and nursing practice. The total number of hours per week for theory and practice was 29. A careful evaluation of the course revealed its value. Not only was it made possible for nursing assistant students, where appropriate, to transfer to nursing diploma studies but nursing diploma students who found they could not cope could transfer to the nursing assistant course. In both cases this could be done without having to repeat the initial semester.

647. KRAMER, M. **Reality shock: why nurses leave nursing.** Saint Louis, Mosby, 1974, xi, 249pp. £4.60

Reality shock is a term used to describe the phenomenon experienced by new workers when they find that many professional ideals and values are not operational and go unrewarded in the work setting. This is a report of eight years of study and research into the problem among young graduate nurses and of a test of the effectiveness of an experiment designed to do something about it, the anticipatory socialization programme. This programme was designed to acquaint student nurses with the realities of nursing today and to share with them the ways in which nurses are postulating how to solve conflicts and make their visions of the future a reality.

648. SCHRÖCK, R. A. **Nurse tutor students' experiences in teaching practice.** *Nursing Times*, London, 1975, Feb. 20, vol. 71, no. 8, occasional papers pp. 9-12; Feb. 27, vol. 71, no. 9, occasional papers pp. 13-15.

The Department of Nursing Studies, Edinburgh University, runs a two-year course leading to the Certificate (or Diploma in the case of graduate students) of Nursing Studies (Education) and eligibility for registration as a nurse tutor. Various approaches to providing and integrating teaching practice in the programme were tried but it does not fit in neatly and satisfactorily for all concerned. Details are given of the arrangements for pre-course teaching experience, first-year teaching practice and second-year teaching practice which have now been incorporated into the programme. This is an account of the experiences in teaching practice of a group of nurse tutor students and their teachers. It illustrates some of the problems and it is hoped that it also shows some ways in which the somewhat artificial 'teaching practice' might become a stimulating experience for everyone involved in it.

649. BENDALL, E. **Teachers of nurses—are there enough?** *Nursing Times*, London, 1975, Feb. 20, vol. 71, no. 8, pp. 288-289.

In six years the number of nurses engaged in teaching in Britain has increased from 2,429 to 3,117—an average annual growth of 115 (four per cent). At this rate it would take 16 years to reach the 5,000 needed for the 1:15 ratio of tutors to students proposed in a recent report. But 500 new teachers are now being registered annually and, allowing a five per cent retirement rate, the required level would be reached in five years. The General Nursing Council is carrying out a survey of all registered clinical teachers and nurse tutors in order to obtain more details on the current position: a first report should be published in the spring of 1975.

650. O'NEILL, J. **A planned programme—with Briggs in mind.** *Nursing Times*, London, 1975, Feb. 20, vol. 71, no. 8, pp. 303-306.

The new January 1975 intake of student and pupil nurses at Wythenshawe Hospital,

Manchester, school of nursing will follow a planned programme pattern of training which is described in this paper. The programme provides a mix of basic experience during the first year; it ensures that night duty is not undertaken before the end of the first year and that there is continuous cover of wards by both students and pupils. The paper includes charts showing the syllabus for both types of nurse, a list of basic nursing procedures, and specimen ward rotas. A unit has been set up in the training school which enables learners to study at their own pace: the 'learning package' on a particular theme may include books, slides, tapes, a small teaching machine, charts, models, or other suitable items. There is a rota of tutors who can be consulted if necessary.

651. RIDGEWAY, S. **The new graduate in the O.R.** *Hospital Administration in Canada*, Don Mills, Ont., 1975, Jan., vol. 17, no. 1, pp. 18-19, 30.

A newly graduated nurse in Canada has had little or no theatre experience: in this paper a nurse who graduated four years ago and opted for theatre work examines the factors which could attract a nurse to such work. These include: opportunities for team work; the chance to satisfy an interest in science; the opportunity to see results; and the aura of excitement. There is job satisfaction, and the opportunity for learning by in-service training. During her period of orientation the theatre nurse's performance should be evaluated informally and at the end of it there should be written tests with further discussion.

652. MORIN, S. **Training the new grad nurse in the O.R.** *Hospital Administration in Canada*, Don Mills, Ont., 1975, Jan., vol. 17, no. 1, pp. 22, 24-25.

Sudbury (Ont.) General Hospital has established a six-months' training course in operating theatre work for registered nurses and six students registered for the first course. The clinical instructors were selected from theatre staff. The first two weeks were devoted to basic orientation: by the fourth week students were in the theatre from 07.30 to 09.30, in the classroom from 09.45 to 11.30, and again in the theatre later for two more hours. Subjects covered included gynaecology, digestive and respiratory systems, circulation, musculoskeletal system, nervous system, plastic surgery, paediatrics and emergency surgery, and special sensory organs. There were weekly discussion sessions and formal examinations and spot tests were held at intervals during the course.

653. RAVENSCROFT, M. M. **Nurse in the haematology unit.** *Nursing Times*, London, 1975, March 13, vol. 71, no. 11, pp. 420-421.

The role of the nurse in the haematology department is to reassure and care for the patient, to chaperone, to assist the doctor and to carry out basic out-patient nursing tasks as may be required. Medical, technical and clerical staff are thus freed from any nursing duties to carry out their specialist work; this helps to provide a better service to the patient. Versatility is the key to nursing in new specialist areas. There are no set rules, no previous pattern to follow and the nurse should have no preconceived ideas about job specification. The nurse should resist the temptation to become an amateur technician; instead she should use her ability to understand the patients' problems.

654. FENN, M., MUNGOVAN, R. and TOWELL, D. **Developing the role of the unit nursing officer.** *Nursing Times*, London, 1975, Feb. 13, vol. 71, no. 7, pp. 262-264.

The authors discuss the changes which have taken place in the organization of nursing services at Fulbourn [Psychiatric] Hospital since an investigation into their work was set up in 1972. At that time the six unit nursing officers shared a central nursing office where one of them was always on duty. They were then required to devote a good deal of their time to non-nursing duties. As a result of subsequent changes nurses have been able to spend more time on their units and have been encouraged to take responsibility for developments in their units within general policy lines. Unit nurses are given more information about general developments in psychiatry and future plans in this field. There are now monthly meetings with administrators and unit nursing officers meet daily.

OTHER PROFESSIONAL AND TECHNICAL STAFF

See also Abstract No. 721

655. **Special issue on biomedical engineering education and employment.** *IEEE Transactions on Biomedical Engineering*, New York, 1975, March, vol. BME-22, no. 2, pp. 89-149.

This special issue contains 13 papers which discuss many of the accomplishments, concerns, projections and problems of biomedical engineering, which is a relatively new interdisciplinary profession striving for identity, quality control and acceptance. In addition to general papers, the issue includes a survey analysis of bioengineering courses in the United States and papers on the courses at the University of Washington, Seattle, Washington University, St. Louis, Worcester (Mass.) Polytechnic Institute, Carnegie-Melton University, Pittsburgh, and California State University, Sacramento.

ORGANIZATION AND ADMINISTRATION

See also Abstract Nos. 641, 702

656. BEHRMANN, W. Leistungsverbesserung durch Delegation von Aufgaben und Verantwortung. **[Improved productivity through delegation of duties and responsibility.]** *Österreichische Krankenhaus-Zeitung*, Wien, 1975, Feb., vol. 16, no. 2, pp. 94, 97-100, 103-105.

This paper deals with two aspects of the problem of delegation among hospital staff: proper measures for co-ordination; and the necessary pre-conditions for delegation. The first is illustrated by an account of how a hospital changed from a decentralized to a centralized cleaning service. A working party representative of all interests was set up; all staff were fully informed and given suitable training; after a limited experiment the scheme was gradually extended to the whole hospital. On the creation of a proper climate for delegation it is most important that central management should concern itself mainly with determining policy and laying down general guidelines: the running of departments, and groups within departments should be in the hands of supervisors at the appropriate level. The responsibilities of each officer should match his abilities.

657. GILLIS, S. **Preparation of hospital manual.** *National Hospital*, Chippendale, N.S.W., 1974, Sept., vol. 18, no. 9, pp. 23-28.

A hospital manual was produced to coincide with the completion of the first stage of the redevelopment of Sydney Eye Hospital. This paper discusses the management functions that the manual is intended to serve, the methods used to produce it, some of the problems met with in its preparation and introduction, and its proposed development. There are currently 10 sections in the manual: annual report; administrative; out-patient services; in-patient services; operating theatre procedures; pathology and paramedical services; general services; financial administration; medical clinical; and nursing clinical.

658. PHILLIPS, R. I. **The informal organization in your hospital.** *Radiologic Technology*, Baltimore, 1974, Sept./Oct., vol. 46, no. 2, pp. 101-106.

In every organization there exist formal and informal systems of social interaction which seem to pull and tug at the very objectives of the organization. The formal organization is well shown on the organizational charts, but the informal organization within the hospital is rarely shown on such charts. Informal groups develop to meet the following functions: perpetuation of culture; provision of social satisfaction; communication; and social control. While there are many benefits derived from the informal organization, there are also areas of difficulty: resistance to change, role conflict and group conformity. The formal organization needs to dominate so as to maintain unity toward managerial objectives, but a strong informal system cannot be precluded.

659. GRIFFITHS, J. W. **Liaison work in a large hospital.** *Health and Social Service Journal*, London, 1975, Feb. 1, vol. 85, no. 4424, pp. 230-231.

The new Charing Cross Hospital at Fulham, which at present has 768 beds was formed from the old Charing Cross Hospital and its medical school, Fulham Hospital, and part of the West London Hospital. Each of these had a set of established routines. The staff of the new hospital was mainly created from that of the old hospitals. Problems arose in connection with the communication of data (especially diagnostic data) from one part of the hospital to another. A liaison officer was appointed whose job it was to receive information about delays and failures and to discover and report on their causes. The officer was made accessible by means of a 'bleep' to meet people identifying delays. He could then take down the necessary details and try to find out the reasons for failure. The officer's work lasted for 16 weeks, from April to July 1974. During this time 374 cases of failure and delay were investigated and weekly reports were made to the administration. Tables in the text show who drew the officer's attention to the delays and which departments were thought to be at fault. The most glaring cause of delay and failure is lack of adequate clerical work on the part of certain clinicians. It was also shown that work was being retarded by a specimen and delivery service which was not running very smoothly. The liaison officer's work can provide pointers to areas which need to be reviewed and possibly rectified. He can also effect improvements in the system in an informal way. The pilot project will not be continued but similar work will be done by an administrative officer who will combine it with his other duties.

ECONOMICS OF HOSPITAL MANAGEMENT

660. SCHILLING, G. W. **Cost containment through sharing.** *Hospitals*, Chicago, 1975, Jan. 16, vol. 49, no. 2, pp. 48-51.

A number of hospitals in Minneapolis-St. Paul have joined to implement sharing of services. A shared laundry facility was established in 1970 under the name of Community Hospital Linen Services; at the end of 1974, seven hospitals with a total of 2,500 beds used the service. A combined credit and collection service, Affiliated Hospital Services (AHS), began operating in July 1969. AHS is a member of the shared computer system of Blue Cross and Blue Shield of Minnesota. In September 1970 AHS took over the printing service of one hospital, which was already serving other hospitals. Currently, 33 hospitals with a total of 7,000 beds participate in AHS; it has 36 full-time and four part-time staff, with several others on-call.

RUNNING COSTS

661. MICHELA, W. **Defining and analyzing costs—a statistical approach.** *Hospital Financial Management*, Chicago, 1975, Jan., vol. 29, no. 1, pp. 36-41.

This paper presents a method of determining hospital costs which can help to explain why costs and staffing patterns vary between hospitals. A survey was made of 2,412 short-stay hospitals with less than 500 medical and surgical beds during a six-month period ending in June 1973. The information was analysed by classifying all institutions according to their number of beds, then according to the average length of stay of patients. The analysis of 'cost per patient day' in each institution revealed that high cost hospitals tended to be in richer areas, and low cost hospitals in poorer areas. A 'labor pool index' for each hospital was then devised, using the national average hourly salary, and by adjusting the 'cost per patient day' according to this, the effects on costs produced by the hospital being in a rich or a poor area were excluded. This adjustment then allowed other factors, such as management policies, to be detected as the cause of unusually high or low costs. Valuable comparisons could also be made between institutions, based solely on the level of service provided. Eleven tables and diagrams illustrate the author's statistical method.

BED OCCUPANCY, ECONOMIC USE OF BEDS

See Abstract No. 746

APPOINTMENT SYSTEMS, WAITING LISTS

662. TEW, M. **Surgical waiting lists and turnover intervals.** *Hospital and Health Services Review*, London, 1975, March, vol. 71, no. 3, pp. 90-93.

With a given number of beds in any specialty the number of patients who can be treated depends on the average length of stay and the turnover interval. Since 1956

length of stay has been reduced considerably in most specialties while the average turnover interval has lengthened. In two specialties—general surgery and gynaecology—the turnover interval has since 1956b een consistently shorter than in five others—ear, nose and throat, plastic surgery, radiotherapy, ophthalmology, and thoracic surgery. Calculations show that, if the turnover interval in 1973 had been the same as for general surgery, potential additional discharges would have exceeded the number on the waiting list at the end of the year by a large margin in radiotherapy and thoracic surgery and by a small margin in ophthalmology: in ear, nose and throat they would have equalled one third of it and in plastic surgery about one fifth. If the calculation is repeated for earlier years there would have been cumulatively since 1956 a potential increase in discharges greatly in excess of the waiting list at the end of 1973. It would be useful to know why there has been this consistently less intensive use of beds in certain surgical specialties.

DATA PROCESSING

See also Abstract Nos. 666, 671, 711, 714

663. Journée sur l'informatique hospitalière, 20 septembre 1974. **[Study day on hospital information systems, 20 September 1974.]** *Gestions Hospitalières*, Mantes, 1975, Jan., no. 142, pp. 19-64.

The papers given at this study day were on: hospital information in France in relation to the principal western countries; a system of patient administrative records; information and hospital management analysis; the information service at the Gustave Roussy Institute; computer analysis of electrocardiograms; automatic treatment of medical certificates; the contribution of data bank techniques in public health; and one year's experience of a data bank in toxicology. The discussions following the papers are also included.

664. **On-site computer proves itself.** *Hospital Administration in Canada*, Don Mills, Ont., 1975, Jan., vol. 17, no. 1, pp. 40, 42.

A mini-computer (an IBM System/3 model 10), installed at the 555-bed Misericordia Hospital, Edmonton, Alta., in May 1973 has proved to be a success. It was first used for processing the payroll and later the computer gradually took over the inventory, out-patient accounts and cash receipts, in-patient accounts, Patient Activity Studies, and hospital census. At present its use for clinical data is under consideration. Misericordia is the first hospital in Alberta to install the mini-computer system but a number of other hospitals are now considering such a move.

ORGANIZATION AND METHODS, WORK STUDY

665. SALVEKAR, A. **Management engineering reduces cost/improves care.** *Hospital Progress*, St. Louis, 1975, Jan., vol. 56, no. 1, pp. 28-30.

After having experienced the benefits of work study on a consultative basis since 1964, St. Cloud (Minn.) Hospital appointed its own full-time officer in 1969 and now

has two work study officers and a systems analyst. Among the results of investigations have been the reduction of nursing groups from 18 patients to 10 to 12, the setting up of quality control programmes for 14 of the 17 ward units and for a number of treatment and service departments and a method for determining nursing staff complements. Work study has led to an annual reduction in costs of $200,000, although it is emphasized that cost reduction is not the sole aim: increased expenditure could well be necessary to ensure efficiency in certain instances.

MEDICAL RECORDS

See also Abstract No. 734

666. NEURATH, P. W. and others. **A selective patient information system.** *Cancer*, Philadelphia, 1974, June, vol. 33, no. 6, pp. 1653-1663.

A patient information system is described in the light of present needs and possibilities. Current shortcomings of medical records are in the areas of completeness, organization, timeliness and retrievability. As part of the solution, the use of an on-line computer system in the Department of Therapeutic Radiology, Tufts-New England Medical Center, Boston, Mass., is described. The system, which has been in use for over 18 months, is based on a Digital Equipment Corporation PDP-11/20 computer. MUMPS, both a high-level computer language and an operating system, forms the basis of the software used. Costs of the system are shown to be comparable to current manual record-keeping due to recent dramatic improvements in cost-performance of large mini-computers. Refinement of the medical data items is still in progress.

HOSPITAL STATISTICS

667. MCNEILLY, R. H. and MOORE, F. **The accuracy of some Hospital Activity Analysis data.** *Hospital and Health Services Review*, London, 1975, March, vol. 71, no. 3, pp. 93-95.

Hospital Activity Analysis (HAA) data were obtained on patients in six Welsh hospitals who had blood transfusions in 1971: the total amount of blood used was compared with the figures in the annual report of the regional blood transfusion service (BTS). Further data were obtained on patients at two hospitals who had had a specified operation with or without blood transfusion: these were compared with theatre records and blood bank registers. Gross deficiencies on the total amounts of blood used were found for all six hospitals: at best only 62 per cent of the blood recorded by the BTS appeared in the HAA records and in some cases the deficiency was much greater. Much of the under-recording was found to be the result of omission from the HAA of many patients who had had transfusions.

LEGAL ASPECTS OF HOSPITAL ADMINISTRATION

See Abstract No. 754

FINANCE AND ACCOUNTING

FINANCE

See also Abstract No. 713

668. BERMAN, H. J. and WEEKS, L. E. **The financial management of hospitals. 2nd edition.** Ann Arbor, Mich., Health Administration Press, 1974, xii, 443pp. $12.50

The authors have attempted to revise and update the first edition of this book to reflect the changing health care financial environment and to make it a more complete and useful reference and teaching document. Statistical data have been updated to reflect current performance and facts. The volume is in three parts: (i) introduction (financial management, accounting principles and financial organization); (ii) sources of operating revenues (sources of revenue, cost analysis, Blue Cross, Medicare and Medicaid, charges and rate setting, and the future); and (iii) working capital management (general principles, financing working capital, inventory management, accounts receivable management, cash and short-term investments and management reports). Also included are a glossary and a bibliography; part of the latter includes abstracts.

669. NAZZARO, E. and VITALE, A. Il finanziamento dell'assistenza ospedaliera. **[Financing hospital care.]** *Problemi della Sicurezza Sociale*, Roma, 1974, Sept./Oct., vol. 29, no. 5, pp. 669-681; summaries in French, English, German and Spanish pp. 682-683.

Investigation shows that as hospital costs have risen most developed countries have provided increasing financial support. As a result there is a problem of creating a balance between those who provide the finance and those who manage the expenditure. There are two alternative solutions: (i) negotiation of rates between hospitals and the actual payers; and (ii) transfer of any regional administrative responsibility to local bodies. In Italy the second solution has been chosen. The advantages are: (i) creation of a modern and effective hospital fund and abolition of the rate to be paid for the time spent in hospital; and (ii) continuation of the legal status of hospitals and use of sound management principles. Some financial aspects of the British National Health Service are examined. [This abstract has been prepared from an English summary of the paper.]

670. VELDMAN, E. A. **Credibility index can measure budget's reliability.** *Hospital Financial Management*, Chicago, 1975, Jan., vol. 29, no. 1, pp. 32-35.

Often budgets prove unreliable, and there has been no reliable way of increasing their credibility. The budget credibility index (BCI) can be computed using the formula: $BCI = 100\% \frac{\text{budget variance}}{\text{budget amount}}$. Ideally, a BCI should be calculated for: (i) total operating revenue (net of deductions); (ii) total operating expenses; (iii) total salaries; (iv) total non-wage expenses; (v) total man hours or full-time staff equivalents; (vi) in-patient admissions; and (vii) in-patient days. Various other expenses may also

need to be included. The BCI is useful in several ways: (i) in the long term, annual budgets can be compared for credibility and accuracy; (ii) departmental BCIs can isolate problem areas of the budget; (iii) variances deviating from the basic BCI standard, which is suggested as 97 per cent, can be identified and corrected; (iv) third parties, such as accountants, who are vitally concerned with the hospital's budget can also use the BCI; (v) the BCI could help all hospitals to meet necessary budget specifications, particularly if these become subject to governmental control; and (vi) the national evaluation of budgeting in hospitals using the BCI could provide a forum for discussion between hospitals and also with third parties.

HOSPITAL ACCOUNTING

671. MUSGROVE, N. **Management accounting system for a health authority.** *Management Services in Government*, London, 1975, Feb., vol. 30, no. 1, pp. 26-34.

The development of a comprehensive integrated management accounting system for use at Moorfields Eye Hospital began in the early 1960s [see *Hospital Abstracts*, Vol. 5, Abstract 547, Vol. 9, Abstract 575 and Vol. 14, Abstract 969]. The MISER (Moorfields Information System Exception Reporting) system in its present form has been fully operational since April 1973 and is the joint product of the hospital and its computer consultants. This description of the system does not provide basic technical details, but attempts to highlight the more important and interesting features of the MISER system. It covers: data input and validation; the coding structure; payroll integration function; nominal ledger function; and management information function.

CATERING, DIETETICS, KITCHENS

HOSPITAL CATERING

See also Abstract Nos. 621, 637

672. KNICKREHM, M. E. and WERTZ, R. A. D. **Personal history and job tenure of dietary employees.** *Journal of the American Dietetic Association*, Chicago, 1975, Jan., vol. 66, no. 1, pp. 34-37.

This paper reports a study in three hospitals which sought to identify how individual characteristics reported on application forms might relate to the length of tenure of employees and how they could be used in staff selection. Three personal history characteristics were found to be statistically significantly related to tenure. When these relationships were examined in combination with all other variables, however, there was no basis for developing a formula which would weigh each personal characteristic according to the strength of its relationship to job tenure. Since personal history characteristics cannot be used to predict job tenure precisely, it can be assumed that situational factors play a more important role in reducing turnover. If a high turnover rate is a problem, such factors as type and degree of supervision, personnel policies and staff training should be examined as possible reasons for turnover.

673. BALK, T. and DUNNE, M. **An evaluation of patients' meals.** *Health and Social Service Journal*, London, 1975, Feb. 22, vol. 84, no. 4427, pp. 428-429.

The South East Thames Regional Health Authority and the *Good Food Guide* have developed a method of evaluating and comparing catering performances in hospitals. It combines a questionnaire survey of patients' attitudes to their meals with independent evaluations of the food by inspectors from the *Guide*. Following a pilot study on nine hospitals early in 1973, two studies, one of 37 long-stay hospitals and another of 21 short-stay hospitals, were undertaken. The first main study enabled the 37 hospitals to be ranked in order of patients' satisfaction with meals. Findings covered such matters as the effect on patient satisfaction of age of patient, size of hospital, food transport methods, choice of menu, time of evening meal and expenditure. The study of short-stay hospitals was limited by finance and the inspectors visited only a selection of hospitals; however, 2,750 questionnaires were completed. The three major findings were similar to those of the long-stay study: (i) older patients were generally more satisfied than younger ones; (ii) the smaller the hospital the greater the patient satisfaction; and (iii) there was very little relationship between expenditure on food and level of satisfaction. Choice of dishes tended to make short-stay patients more satisfied. Male patients were more satisfied than female patients though satisfaction of the latter improved with length of stay. Features most adversely criticized were appearance of food, variety and temperature. The project was considered to be very useful and some remedial action has already been taken to overcome deficiencies.

674. JONG, J. P. de. Maaltijden programmeren in de ziekeninrichting. **[Menu planning in the hospital.]** *Ziekenhuis*, Utrecht, 1975, Feb. 5, no. 3, pp. 58-59.

Formerly St. Laurens Hospital, Breda, worked out and costed its menus each week at a time-consuming committee meeting called for the purpose. This has now been changed by dividing the year into five summer months and seven winter months and working out a six-week menu cycle appropriate to each session. Budgeting is on an annual rather than a weekly basis. The six-week cycle means that most patients never have a repeat of the same menus. If a patient does not like the menu meal for a particular day he can order 'à la carte' from a variety of attractive dishes. The completion of patients' meal cards and the serving and clearing away is done by special assistants, one of whom is attached to each ward: these assistants make sure that patients' wishes are carried out and they report back to the catering officer so that menus are based on popular demand. In 1974 the cost per food day was fl.4.66 (about 85p).

DIETETICS IN THE HOSPITAL

675. REEL, L. C. **Consultant dietitians effect change by working with administrator and foodservice supervisor.** *Journal of the American Dietetic Association*, Chicago, 1975, Jan., vol. 66, no. 1, pp. 45-47.

The consultant dietitian can effect great improvement in a department of dietetics by performing the necessary organizational and administrative procedures. Her major objective is to effect desirable changes; this objective must be achieved primarily

through motivation as the dietitian's staff position limits her use of authority. The personal characteristics required by a consultant dietitian and the problems she will encounter are outlined. The paper also discusses the relationship between 'line' and 'staff' functions, the value of good human relations, aids to productive consultation and professional responsibilities.

KITCHENS

See Abstract No. 621

CANTEENS, STAFF DINING-ROOMS

See Abstract No. 627

LAUNDRIES AND LINEN SERVICE

LAUNDRIES

676. BROWN, E. **Laundry and linen services: how to come out cleanest.** *Hospital Housekeeping*, Los Angeles, 1974, Nov./Dec., vol. 3, no. 6, pp. 9-12, 26.

There are three basic types of laundry service—commercial service, in-house laundries and central laundry service. A commercial service means that the hospital saves on space and staff but it has less responsibility for the laundry and less control over it. In-house laundries are often the most popular choice of housekeepers—given no space or initial investment limitations. Central or shared services may be owned by one hospital or by a commercial organization. Participating hospitals are freed from owning or maintaining their own laundry yet together they have more power than if dealing separately with the same laundry. A hospital with a successful in-house service may reduce its expenses by offering it to other hospitals on a commercial basis. The advantages and disadvantages of the three systems are considered in relation to several hospitals in the United States.

677. BRYANT, M. E. **Modern development in hospital laundries.** *Hospital Engineering*, Stevenage, 1975, Jan./Feb., vol. 29, pp. 5-8, 11-12.

The advent during the last 10 years of large-capacity laundering machines has led to widespread changes in the design and equipment of hospital laundries. The tendency now is for small local laundries to be replaced by central laundries capable of processing up to 100 tons of linen a day. This paper discusses the equipment and organization of such laundries and describes the workflow, transport and handling systems required for processing linen from the bedside back to the bedside. The paper includes sketches of the layout of laundry premises and photographs of transport systems, washing machines and other equipment.

678. MÅNSSON, L. and NYSTRÖM, B. Desinfektion av sjukhustvätt. **[Disinfection of hospital washing.]** *Sjukhuset*, Göteborg, 1975, vol. 52, no. 1, pp. 4-7.

The effects of washing polyester/cotton overalls in a 275 kg. batch rotatory washing

machine and a 700 kg. per hour counterflow machine were tested bacteriologically with the strains of *Streptococcus faecalis*, *Acinetobacter anitratum* and *Staphylococcus aureus*, and technologically with a maximum thermometer. The *Acinetobacter* strain showed the greatest resistance, but the laundry routines applied were both satisfactory. Reduction of the temperature for 10 to 12 minutes to 70°C from the current 90°C had no deleterious effect on the result. It is therefore recommended that overalls worn by staff nursing patients with diseases of normal infectivity should be washed at 70°C instead of 90°. The temperature of the water in the machines should be checked daily. The machines used and test methods employed are illustrated and the bacteriological results are summarized in four tables.

HOSPITAL LINEN AND TEXTILES

See also Abstract No. 676

679. BRIDGES, T. **Process control in linen services.** *Health and Social Service Journal*, London, 1975, Feb. 1, vol. 85, no. 4424, pp. 237-238.

In order to establish control of a situation the task must be defined and the objectives established. Once the total function and operational needs are known the method of operation and control can be formulated. In the health service, providing adequate records have been kept, information concerning the total load and breakdown by classification should be available. The process controls are considered for the various departments of the laundry, i.e. reception, sorting room, washroom, finishing department, and packing and despatch. The listing of control factors for each of these departments should be the starting point of any plan of process control. Once the control systems have been worked out it is the responsibility of management and engineering staff to monitor and maintain them if an efficient service is to be ensured.

HOSPITAL DOMESTIC MANAGEMENT

DOMESTIC WORK

680. SRINIVAS, M. **OR cleaning standards: are they possible?** *Hospital Housekeeping*, Los Angeles, 1974, Nov./Dec., vol. 3, no. 6, pp. 13-15.

An investigation was made into whether it is possible to fix standards for cleaning operating theatres, irrespective of the size or type of the hospital. The views of executive housekeepers of American hospitals interviewed varied considerably on this. The three usual methods of cleaning operating theatres are: the 'floor mop' method—basically flooding the floor with a bucket of germicidal solution; the sprinkler can system which uses a vessel similar to a garden watering can to sprinkle the floor with germicidal solution; and the compression sprayer system, whereby germicide is placed in a compression can, pumped under pressure and sprayed on floor and walls. The actual procedures used in a number of hospitals are briefly described. Standardization would make it easier to train new staff but some house-

keeping managers prefer to make their own decisions on their own requirements. It is essential that allocation of areas of responsibility between theatre supervisors and executive housekeepers be agreed. If standardization is to come a body such as the American Hospital Association or the American Medical Association will have to be responsible for making such decisions.

HYGIENE IN THE HOSPITAL

681. BAUER, P. Krankenhaushygiene. **[Hospital hygiene.]** *Mitteilungen der Österreichischen Sanitätsverwaltung*, Wien, 1975, Jan. 15, vol. 76, no. 1, pp. 1-6.

Some basic principles of hospital hygiene are discussed under five heads: the ward; the operating suite; sterilization; disinfectants; and planning. On the ward attention to hand washing and disinfecting, the changing of protective clothing, disposal of soiled linen, surface disinfection and washing up is important. In the operating suite special attention should be paid to clothing regulations and the risks attaching to air-conditioning and cooling installations; recommendations are given on the use of demineralized and germ-free water. Deficiencies in sterilization procedures are discussed and some advice given on the inspection of apparatus. Guidance is given on the choice of disinfectants which must always be appropriate for the particular purpose and be applied in the correct dilutions. A hygienist should always be included in the planning team of a new hospital from the earliest stage.

HOSPITAL INFECTIONS

See also Abstract No. 640

682. REBEL, M. H. and others. **The flora of renal haemodialysis shunt sites.** *Journal of Clinical Pathology*, London, 1975, Jan., vol. 28, no. 1, pp. 29-32.

Staphylococcus aureus is the most frequent pathogen of haemodialysis shunt sites and was endemic in the investigations reported in this paper. It was not found possible to predict clinical infection by a preceding colonization of the shunt site by a pathogen. The normal non-pathogenic flora of the sites is not specifically related to the flora of other sites of the body though *S. aureus* on a shunt site seemed to be acquired mainly from the nose when the shunt was in the arm, or from the perineum when the shunt was in the leg. Cimino shunt sites had a higher density of organisms than Scribner shunt sites: this may be related to disinfection procedures.

683. ALTER, H. J. and others. **Health-care workers positive for hepatitis B surface antigen: are their contacts at risk?** *New England Journal of Medicine*, Boston, Mass., 1975, Feb. 27, vol. 292, no. 9, pp. 454-457.

To assess the hepatitis risk to patients exposed to staff positive for hepatitis B surface antigen (HB_s Ag), 228 contacts were followed prospectively for six to nine months. The staff included two physicians with chronic hepatitis, a chronic asymptomatic nurse carrier, a food handler with acute HB_s Ag-positive hepatitis and a physician who was HB_s Ag-positive for 25 days before the onset of acute hepatitis. Controls consisted of 127 identically followed patients who had not been exposed to

HB_s Ag-positive staff. No exposed or control patient acquired clinical hepatitis or HB_s Ag. Isolated elevations in serum glutamic pyruvic transaminase occurred equally in both groups and did not correlate with serologic evidence for hepatitis B infection. One exposed patient demonstrated antibody seroconversion (anti-HB_s), as did two of the controls. These data do not demonatrate hepatitis B transmission from HB_s Ag-positive staff to their patients. Restriction of such carriers is not warranted at present.

684. DOWSETT, E. G. and others. **Outbreak of idiopathic erysipelas in a psychiatric hospital.** *British Medical Journal*, London, 1975, March 1, vol. i, pp. 500-502.

Ten cases of idiopathic erysipelas occurred between 10 March and 4 May 1973 in three wards of a separate five-ward unit for about 300 long-stay female patients in a 1,400-bed psychiatric hospital. Group A streptococci M-type 1 were isolated from two patients with erysipelas and 18 carriers, but subsequent serological tests showed that the infection had been widespread in the unit. Treatment with ampicillin proved ineffective and to prevent relapse it was substituted by a standard course of intramuscular penicillin. This seems to be the first epidemic of this type to be reported.

SOURCES OF INFECTION

See also Abstract Nos. 683, 689, 692

685. SEXTON, D. J. and HAYNES, B. **Bird-mite infestation in a university hospital.** *Lancet*, London, 1975, Feb. 22, vol. i, pp. 445.

The common pigeon has proliferated in large numbers near Duke University Medical Center. In addition to the annoyance of their untidy habits, there has recently been another complication of their presence—an outbreak of mite infestation. A patient with full extremity casts on both arms and legs was readmitted after discharge with *Haemophilus influenzae* meningitis. A day later he complained of general pruritus that was especially severe in areas covered by the casts. Small mites were detected on the patient and his bedsheets; numerous mites were observed under the casts when they were replaced. Three regular visitors to the patient complained of pruritus associated with the same mites, as had three previous occupants of the room. A bird's nest was discovered in a vent in the ceiling of the room; it was filled with countless mites. Similar nests and mites were found in other ventilation ducts on the same floor. Control measures included washing the patient with 'Kwell' soap, removing the nests, spraying the room and ducts with one per cent pyrethins and 12 per cent piperonyl butoxide, and then thoroughly cleaning the patient's room. There has been no further evidence of mite infestation.

PREVENTION AND CONTROL

See also Abstract No. 694

686. AMERICAN HOSPITAL ASSOCIATION. **Infection control in the hospital. 3rd edition.** Chicago, American Hospital Association, 1974, xiii, 198pp. $6.50.

Many sections and chapters have undergone extensive revision in the third edition of this manual (see also *Hospital Abstracts*, Vol. 9, Abstract 593 and Vol. 11, Abstract

567). These include methodology of surveillance and reporting, blood bank, surgical suite, intensive care unit and newborn nursery. There are completely new sections on haemodialysis units, carpeting, fogging and laminar flow. The report forms have been modified, and the appendices have been replaced and expanded.

687. BOTZENHART, K. Aktuelle Probleme der Krankenhaushygiene. **[Current problems of hospital hygiene.]** *Öffentliche Gesundheitswesen (Das)*, Stuttgart, 1975, Jan., vol. 37, no. 1, pp. 22-29; summary in English, p. 22.

Hospital hygiene today has to deal with the increased sensitivity of patients to potentially pathogenic micro-organisms, which are able to adapt very readily to their environment. This fact has been largely ignored in the construction and organization of hospitals. In addition to the basic design such installations as air-conditioning, suspended ceilings, internal transport systems, baths, and cleansing equipment show a profound lack of understanding of the elements of infection prevention. The same applies to the carrying out of cleaning and disinfection procedures which are often ill-considered and inadequate. An essential prerequisite for improvement in this field is regular microbiological surveillance.

688. TREXLER, P. C. **Microbial isolators for use in the hospital.** *Biomedical Engineering*, London, 1975, Feb., vol. 10, no. 2, pp. 63-67.

An isolator consists of a microbially impervious barrier enclosing a work space through which all observations and manipulations within the protected space must be made and across which materials must be moved without violating the microbial integrity of the barrier. Isolators have been used clinically in both operating theatres and wards. A surgical isolator recently developed provides a means of eliminating wound contamination during the implanting of large prostheses. The sterile surgical field is enclosed in an envelope of thin polyvinyl chloride film 2.4 m. long and 0.9 m. in diameter. Surgical gloves can be attached to as many as six pairs of blind sleeves distributed along the sides and at one end. All members of the surgical teams have found the isolators easy to use though there are some limitations, for example the surgeon cannot move around the table without changing his gloves. In wards isolators have been used to protect patients from pathogens in the environment and to contain patients with a contagious infection. At Hammersmith Hospital bed isolators have been used over three years to help in the therapy of patients with acute myeloid leukaemia. A diagram of an isolator is given and there are four photographs illustrating their use.

689. WALTER, C. W. **Cross-infection and the anesthesiologist.** *Anesthesia and Analgesia: Current Researches*, Cleveland, 1974, Sept./Oct., vol. 53, no. 5, pp. 631-644.

This survey of the kinetics of cross infection during anaesthesia makes it clear that the anaesthetist can contribute to the control of hospital infection. The most important step he can take is whole-hearted collaboration with his hospital's infection control committee. Surveillance provides the data that identify endemic problems and indicate the facet of a control programme that must be emphasized. Specific actions which the anaesthetist can take to protect patients are listed.

690. FINN, B. **Education and training of infection control nurses.** *Nursing Times*, London, 1975, Feb. 13, vol. 71, no. 7, ICNA supplement pp. 13-14.

The Joint Board of Clinical Nursing Studies has published an outline curriculum in infection control nursing for state registered nurses. The 24-week course covers the following aspects: infection prevention, surveillance, investigation and control; advice on policy, procedures, materials and techniques; establishing and maintaining good relations with patients and staff; teaching infection control to all grades of staff; and research appreciation. Half the course is to be devoted to practical work and study and half to planned teaching. The Joint Board will grant a certificate to nurses who complete the course successfully.

691. SANFORD, J. P. **Infection control in critical care units.** *Critical Care Medicine*, New York, 1974, July/Aug., vol. 2, no. 4, pp. 211-216.

Inhalation therapy equipment is a potential source of Gram-negative bacilli. However, not all types of equipment are equally dangerous in this regard. Ventilators and humidifiers have minimum potential for transmitting bacteria into the patient's inspired gas. Small-volume Venturi nebulizers are potential disseminators of bacteria, but infrequently do so in hospital use. Large-volume nebulizers of all designs (Venturi, spinning disc or ultrasonic) are the major source of aerosolized bacteria. Sterilization method depends on the design of the nebulizer. It has been demonstrated that most nebulizers can be decontaminated successfully in a clinical setting. Any system of decontamination requires meticulous handling by staff and the application of some type of decontamination procedure at least once every 24 hours.

HYGIENE IN THE OPERATING THEATRE

692. PORTNOY, J. and others. **An outbreak of streptococcal wound sepsis: contamination of the wound during operation.** *Canadian Anaesthetists' Society Journal*, Toronto, 1974, Sept., vol. 21, no. 5, pp. 498-502.

An outbreak of eight post-operative infections due to group A beta-haemolytic streptococci occurred over a one-month period. The probable source was an anaesthetist who had mild unrecognized streptococcal nasopharyngitis. In addition, this anaesthetist often permitted his mask to drop, leaving his nose uncovered for prolonged periods. The careless use of a face mask by this physician may have been responsible for the outbreak. The outbreak was curbed promptly by appropriate control measures. This report emphasizes the need for stringent enforcement of techniques for the prevention of transmission of infection.

693. VARMA, S. and others. **Comparison of seven suture materials in infected wounds—an experimental study.** *Journal of Surgical Research*, Philadelphia, 1974, Sept., vol. 17, no. 3, pp. 165-170.

Suture materials play an important role in post-operative wound infections, and different suture materials elicit different degrees of reaction in a contaminated wound. This paper reports a study, conducted in dogs, to compare the degree of infection enhanced by seven standard suture materials implanted in a field contaminated with

Staphylococcus aureus. Steel and nylon sutures produced considerably less reaction in the presence of infection than braided non-absorbable sutures, polyglycolic acid (Dexon) or catgut.

STERILIZATION

694. AYLIFFE, G. A. J. and GIBSON, G. L. **Antimicrobial treatment of equipment in the hospital.** *Health and Social Service Journal*, London, 1975, March 15, vol. 84, no. 4430, pp. 598-599.

This paper presents tables which show a choice of suggested methods of treatment or re-treatment appropriate to a number of items requiring sterilization or disinfection. The order of choice of method is indicated by the numbers 1, 2, 3 or 4, with brackets indicating that the method is of doubtful value. Equipment is categorized as follows: A—sterilization essential; B—sterilization preferred but disinfection usually adequate; C—disinfection normally sufficient; and D—cleaning sufficient.

695. OPPEDAL, L. V. Hvordan sterilisere? Autoklavering. **[How to sterilize? Use of autoclaves.]** *Sjukhuset*, Göteborg, 1975, vol. 52, no. 1, pp. 16-19.

The types of steam autoclaves are: (i) gravitation-ventilated autoclaves; (ii) autoclaves with pulsating pre-vacuum and steam injection; and (iii) high-vacuum-ventilated autoclaves. Autoclaves achieve their effects by a combination of heat, damp and time, and not all materials can tolerate these factors. Hydrophobic materials such as oils are not sterilized by the autoclave, and certain substances such as glass are more suitably dry-sterilized. There are five timing concepts: pre-heating time, penetration time (the unpredictable quantity), lethality time, safety margin (=half the lethality time), exposure time (=lethality time+safety margin), and sterilization time (=penetration time+exposure time). Modern autoclaves operate efficiently at 120°C, taking about 10 minutes longer than at 134°C. An efficient autoclave must also eliminate pockets of air or the temperature will be significantly reduced. Textiles must not be overheated or they become brittle and their life is reduced; but nor must they remain wet. Faulty loading of the machine (e.g. cold metals on top of textiles) will cause condensation and waterlogging. The air filter in the air intake must be strong, dry, bacteria-tight and subject to frequent inspection. Autoclaving should be centralized and the routines used should be approved by an expert and rigidly enforced.

INSECT AND PEST CONTROL

See Abstract No. 685

SAFETY MEASURES

PLANNING FOR MASS EMERGENCIES

696. RUTHERFORD, W. H. **Disaster procedures.** *British Medical Journal*, London, 1975, Feb. 22, vol. i, pp. 443-445.

Over a three-year period, the Royal Victoria Hospital, Belfast, had to receive multiple casualties from bombs on 48 occasions. The repeated use of the hospital's

disaster plan provided an unusual opportunity to assess the value of its procedures. Two basic principles are presented: the need for a command structure; and the value of sticking to the daily routine rather than establishing special procedures. Some important aspects discussed are: triage; documentation; relationships with the media; disaster organization at the site; rapid transport of patients to hospital; on-site medical officer; and medical teams.

697. SUTHERLAND, S. **'Exercise London'—a community disaster plan.** *Hospital Administration in Canada*, Don Mills, Ont., 1975, Jan., vol. 17, no. 1, pp. 16-17.

An exercise to help disaster planning held in London, Ont., in October 1974 supposed an air crash in the centre of the city. The 150 casualties, 27 of whom were supposedly killed, were strategically placed round the crash site. A fringe team from one hospital went to the scene and casualties were sent to five participating hospitals. The exercise was planned by the London Health Council's emergency medical services committee and they were moderately happy with the way it went. Among points made were that the system for tagging casualties needed revision and that operating facilities in some hospitals would not have been able to cope.

THE PATIENT

ADMISSION AND RECEPTION

See Abstract No. 754

WELFARE OF THE PATIENT

See also Abstract Nos. 623, 736, 737, 747, 755, 760

698. SPEAKMAN, J. **Hospital visitors—a curse or a blessing?** *Nursing Times*, London, 1975, Feb. 13, vol. 71, no. 7, pp. 274-275.

This is a plea for properly organized schemes involving committed volunteers for the regular visiting of long-stay psychiatric or geriatric patients who would otherwise never be visited. Such volunteers can relieve nurses of many non-nursing duties such as reading or writing letters, taking patients for walks, or just listening. It is important that the right type of volunteer is selected and that he or she is welcomed and given useful work to do. The volunteers should form part of the health team and should be encouraged to express their views on hospital activities.

699. WHITFIELD, S. **Noise on the ward at night.** *Nursing Times*, London, 1975, March 13, vol. 71, no. 11, pp. 408-412.

This paper describes a project in two 20-bed male acute surgical wards on the ground floor of a district general hospital; both admitted emergency cases during the day and night. The layout in both was similar—divided into three bays by glass partitions, but with a wide central gangway down the whole ward. A questionnaire

was completed by 55 patients and 16 night nursing staff. The questionnaire is reproduced and summaries of the patients' and nurses' replies are presented in tables and discussed. Twelve of the patients said they were not disturbed by any noise; the remaining 43 mostly indicated only slight disturbance for particular noises on the questionnaire. The project has shown up several areas of noise in the ward at night; they can be reduced if specific measures are taken. Already some of the recommendations made have been put into effect and more are in progress.

VOLUNTARY SERVICE, VOLUNTARY WORKERS

See also Abstract No. 698

700. AMERICAN HOSPITAL ASSOCIATION. **The auxiliary: new concepts, new directions.** Chicago, American Hospital Association, 1974, viii, 235pp.

This manual has been written to provide auxiliaries, and the hospitals they serve, with a new perspective on the auxiliary's role and responsibilities. There are chapters on: the role of the auxiliary; the auxiliary's accountabilities and relationships; membership and leadership; organizational principles; committees; legal considerations; fund raising; education; the dynamics of meetings; records and reports; planning and evaluation; and how to start an auxiliary.

THE GENERAL PRACTITIONER AND HIS PATIENTS

See Abstract Nos. 733, 746

TRANSPORT OF PATIENTS

See also Abstract Nos. 724, 727

701. WADDELL, G. and others. **Effects of ambulance transport in critically ill patients.** *British Medical Journal*, London, 1975, Feb. 15, vol. i, pp. 386-389.

Two groups of critically ill patients were transferred by ambulance from other hospitals to a central intensive therapy unit. The effect of transport was reviewed retrospectively in 46 patients and prospectively in 20 patients, and the results were analysed. Careful resuscitation before transfer, continuing medical care during the journey and a slow gentle journey helped to prevent serious cardiovascular complications in critically ill patients.

HOSPITAL CARE

See also Abstract Nos. 741, 756

702. JOKERST, L. **Unit management: separating myth from reality.** *Hospital Progress*, St. Louis, 1975, Jan., vol. 56, no. 1, pp. 58-59, 64.

A unit manager on a nursing division influences and co-ordinates managerial activity. He does not act as the representative of top management at unit level. He

co-ordinates activity but is not to be burdened with the details of execution. The unit manager should be responsible to the administration by a direct line of accountability rather than to the director of nursing: ward clerks should work to the nursing staff and not to the unit manager. Purpose, organization, leadership and commitment are the four essential elements of a unit management scheme and these are discussed individually.

DISCHARGE OF PATIENTS

See Abstract No. 757

HOME CARE, AFTER-CARE

See Abstract Nos. 742, 743, 753, 758

SPECIAL DEPARTMENTS

WARDS

See Abstract No. 623

OPERATING SUITES

See Abstract Nos. 651, 652, 680

ANAESTHESIA

See Abstract No. 689

PHARMACY

703. ROLANDS, T. F. and WILLIAMS, R. B. **How drugs attain formulary listing.** *Hospitals*, Chicago, 1975, Jan. 16, vol. 49, no. 2, pp. 87-89.

This paper reports a study to determine if hospitals using formularies are effective in their evaluation and selection of drugs for inclusion in the formulary and to determine the extent and nature of formularies in use. A questionnaire was completed by 172 hospitals (56 per cent of those to whom it was sent). The results confirm that hospitals are effective in their selection of drugs in their formularies. Based on the results of the survey, the recommendations and comments of the American Hospital Formulary Service Reference Panel and the literature on the subject, guidelines for hospitals with a formulary are suggested.

704. GROTH, P. E. **Regional drug information service benefits: free versus fee-for-service.** *American Journal of Hospital Pharmacy*, Washington, 1975, Jan., vol. 32, no. 1, pp. 26-30.

Analysis of the 481 replies from users of the Nebraska Regional Drug Information Service, including doctors, dentists, pharmacists and nurses, showed that 52 per cent of the respondents considered that the drug information service was of direct benefit to patients. On the question of charges for the service, a fee of $2.00 to $5.00 per enquiry or $25.00 per year was preferred. It has been calculated that a fee of $2.50 per enquiry would not cover expenses but that the service would break even with a charge of $25.00 a year. Details of the enquiry, with a copy of the questionnaire used, are given in six tables.

705. PEARSON, R. E., LAUPER, R. D. and DAVIS, L. J. **Experience with a drug information services review committee.** *American Journal of Hospital Pharmacy*, Washington, 1975, Jan., vol. 32, no. 1, pp. 31-34.

In order to review and assess the work of the drug information service operated by the School of Pharmacy, State University of New York, Buffalo, a review committee was set up in 1972. This paper presents a detailed analysis of 551 requests for information which is set out in four statistical tables. The conclusion is that the requests were on the whole of average difficulty and that the answers were accurate and useful. To help with the evaluation a questionnaire (a copy of which is included in the paper) was sent to the enquirers who asked the selected questions, in order to get their views on the efficiency of the service.

706. SMITH, G. H., SORBY, D. L. and SHARP, L. J. **Physician attitudes toward drug information resources.** *American Journal of Hospital Pharmacy*, Washington, 1975, Jan., vol. 32, no. 1, pp. 19-25.

In order to determine how the Drug Information Service (DIS) of the University of Washington should be expanded a questionnaire was sent to all physicians in 18 counties of western Washington. An analysis of the 1,227 replies received is set out in five tables. These show that doctors depend mainly on periodicals and textbooks for their drug information and rarely turn to pharmacists for information which would directly affect patient treatment. Just over a third of the doctors expressed their willingness to pay for drug information services.

707. MOGGACH, B. B. **Drug administration times should be reexamined!** *Canadian Nurse*, Ottawa, 1975, Jan., vol. 71, no. 1, pp. 17-19.

A new scheme for timing the administration of drugs has been introduced in a hospital where previously drugs of all types had been given at the same set times. Drugs were divided into five groups as follows: A, those to be taken on an empty stomach; B, those to be taken immediately before or after meals or with food or drink; C, those to be taken half an hour before food; D, long-acting drugs or those to take effect during waking hours; and E, those whose effect is not dependent on dosage intervals and may be taken with or without food. A suitable time schedule was worked out separately for each of these groups: details are set out in a table. The system has

been welcomed by doctors and nurses who had been consulted throughout the planning period.

708. RAPP, R. P. and SACHATELLO, C. R. **Institutional control of prescription blanks.** *American Journal of Hospital Pharmacy*, Washington, 1975, Jan., vol. 32, no. 1, pp. 52-54.

The system used at the University of Kentucky Hospital to prevent the illicit use of drug prescription forms is described. Each doctor wishing to prescribe controlled drugs registers at the out-patient pharmacy, supplying his licence number and a specimen signature. He is issued with a pad of 25 consecutively numbered prescription forms which have stubs to identify each prescription: the stubs of completed pads are filed in the pharmacy. If a prescription pad is lost or stolen all pharmacies in the area are alerted and supplied with the serial numbers of the forms. The system works well.

LABORATORIES

709. HEWER, A. J. H. **The role of a department of physiological (clinical) measurement in the U.K. National Health Service.** *Biomedical Engineering*, London, 1975, Feb., vol. 10, no. 2, pp. 59-62.

There are strong arguments for having a self-contained multidisciplinary department of physiological measurement containing scientists and clinicians backed up by a comprehensive electronics laboratory and a mechanical laboratory capable of handling some heavy work but mainly orientated towards high precision instrumentation. The functions of an ideal department of physiological measurement are: (i) to provide an important and accurate feed-back of data to the clinician, assisting in diagnosis, enabling closer control of treatment and providing an early warning system on changes in the patient's condition; (ii) to supply an efficient 'round the clock' first line maintenance service for monitoring systems and other hardware under the care of the department; (iii) to undertake developmental research and to supply a consultative service to those who come for advice; (iv) teaching and spreading knowledge of its technology to medical staff, nurses, students and hospital administrators; and (v) to co-operate with manufacturers to ensure the best possible equipment. In future perhaps the most important function of a department of physiological measurement will be to act as a meeting place between medical and non-medical scientists where each can educate the other in his own discipline. The paper outlines how the Department of Clinical Measurement at the Middlesex Hospital measures up to these ideals.

710. BÜRGI, W. Der medizinische Laboratoriumsdienst: Dargestellt am Beispiel des Kantonspitals Aarau. **[Clinical laboratory services: Aarau Cantonal Hospital as an example.]** *Biomedizinische Technik*, Berlin, 1974, Aug., vol. 19, no. 4, pp. 146-150.

The Aarau Cantonal Hospital (which will have 800 beds in 1975) has a laboratory which in 1973 carried out a total of 345,003 tests: 83.7 per cent of these were for

in-patients, 10.5 per cent for out-patients and 5.8 per cent were sent in by doctors. The laboratory staff of 50 includes two doctors (one of whom is in charge) and 25 qualified technicians. The laboratory carries out 34 different analyses in haematology and 106 different chemical tests. A list of the apparatus and equipment used is given. The laboratory has been cautious in going over to automation and only now is the installation of autoanalysers being implemented. A decision has not yet been reached on whether on-line electronic data processing should be used.

711. KELLER, H. Laborautomation—Stand und Entwicklungstendenzen. **[Automation of the clinical laboratory—state of the art and trends.]** *Biomedizinische Technik*, Berlin, 1974, Aug., vol. 19, no. 4, pp. 129-134.

This is a survey of the present state of automation in clinical laboratories with a review of recent literature (supported by 36 references). While there are certain tests which are not susceptible to automation the use of machines, including electronic data processing, is likely to increase because of the large number of tests carried out and the serious shortage of qualified technicians. Three of the principle automation systems on the market (the 'Auto-analyzer', the 'Fast analyzer' and the ACA) are described. One of the most intractable problems of electronic data processing is the direct identification of specimens by the name or other symbol of the patient.

712. HARRINGTON, J. M. **Health of laboratory workers.** *Proceedings of the Royal Society of Medicine*, London, 1975, Feb., vol. 68, no. 2, pp. 94-95.

This paper reports briefly a study of the health hazards of laboratory workers undertaken in three phases: (i) retrospective postal questionnaire to all National Health Service, Public Health Laboratory Service and Blood Transfusion Service laboratories in England and Wales; (ii) a mortality study of pathologists and technicians; and (iii) a prospective enquiry over a 12-month period in 10 per cent of the laboratories to determine their sickness absence and accident records. Only 54 per cent of laboratories instruct new staff in safety. Servicing of safety cabinets and to a lesser extent centrifruges is infrequent. In a population of 2,186 staff, 602 accidents resulting in injury occurred; over three-quarters of these occurred to two-thirds of the population, namely the technical staff. No major differences in accident rates seem to distinguish the different pathology disciplines, though microbiology does experience a slightly higher accident rate. Most of the injuries were caused by lacerations. Younger laboratory workers had higher accident rates than older ones, but ethnic origin was of no significance.

713. BENNINGTON, J. L., WESTLAKE, G. E. and LEUVAU, G. E., editors. **Financial management of the clinical laboratory.** Baltimore, University Park Press, 1974, xiv, 167pp. $14.50

The sections in this book are based primarily on a conference on the subject held in San Francisco in May 1973. They are designed to familiarize directors of laboratories with modern concepts and techniques of financial management. There are chapters on: cost analysis; effect of cost/volume relationships on financial results; laboratory test volume planning model; test price analysis; economic evaluation of equipment

purchases; lease or purchase decision analysis; capital budgeting; responsibility budgeting; flexible budgeting; the human side of budgeting; and a linear regression model for forecasting revenue.

714. BEISHON, J. and MARTIN, J. **Automation in a hospital biochemistry laboratory.** In: Information. Unit 9. Man and systems, pp. 25-55. Milton Keynes, Open University Press, 1974. £1.30

This case study describes the equipment and procedures used in the clinical chemistry laboratory of the Royal Victoria Hospital, Belfast, for the automatic analysis of blood plasma for diagnostic purposes. It covers: background; the overall organization; the Auto Analyzers; the interface; the computer; the interim plate report; the ward report; work flow through the day; quality control; and fall-back procedures. Several diagrams are included.

BLOOD TRANSFUSION DEPARTMENT

715. ABELSON, N. M. **Topics in blood banking.** Philadelphia, Lea & Febiger, 1974, viii, 163pp.

The purpose of this book is to summarize and review recent developments in blood banking as well as to cover some subjects, such as inspection programmes, safety regulations and communication, which have not been fully considered elsewhere.

DIAGNOSTIC X-RAY DEPARTMENT

716. DURY, I. M. **Radiology: advantages of operating in the light.** *Hospitals*, Chicago, 1975, Jan. 16, vol. 49, no. 2, pp. 71, 74.

Despite advances in radiology equipment, the darkroom remains a bottleneck in work flow. A five-month study at Nassau County Medical Center, East Meadow, N.Y., has shown that darkrooms can be eliminated by using the X-ray rooms as processing areas. The lighting systems tested were: 60-watt yellow light with Kodak OA safelight filter; 25-watt orange bulb with Kodak ML2 safelight filter; 100-watt yellow light with a Kodak OA safelight filter; and a seven-watt cold cathode lamp, tinted amber. A mobile automatic processor was placed in each room, with necessary services for water, waste and electricity. The department selected the cold cathode tube for its use. The system has been in operation since February 1974 and has resulted in cost savings and improved scheduling of patients.

717. COBBEN, J. J. Kanttekeningen bij de organisatie en bouw van een röntgenafdeling. **[Notes on the organization and construction of a diagnostic X-ray department.]** *Ziekenhuis*, Utrecht, 1975, Feb. 5, no. 3, pp. 66-71.

The data on the planning of diagnostic X-ray departments presented in this paper are based on published work and on figures for the years 1962 to 1971 from the Catharina Hospital, Eindhoven. X-ray examinations are divided into five categories: (i) Bucky without contrast media; (ii) Bucky with contrast media; (iii) fluoroscopy;

(iv) thorax; and (v) clinical examinations. A formula is worked out for each group relating the percentage of total examinations to average examination time, effective working time per room/day and number of examinations per day. From this the number of rooms required for each group for hospitals with from 100 to 1,000 beds to meet 1985 requirements is calculated. It is estimated that the Catharina Hospital, with 814 beds, will need 10 examination rooms in 1972, 11 in 1975, 13 in 1980 and 15 in 1985. It is estimated that of every 100 patients requiring X-rays 32 will be new and 68 old; they will require 125 examinations and 400 films will have to be processed. Calculations are also made of staffing requirements and equipment and other costs.

718. SULLIVAN, W. G. and THUESEN, G. J. **A cost evaluation model for radiology departments.** *Engineering Economist*, Hoboken, N.J., 1975, vol. 20, no. 2, pp. 79-98.

The aim of this paper is to develop a resource requirements model from which reliable information can be produced to assist in deciding among proposed arrangements of diagnostic X-ray facilities in large hospitals. A cost evaluation model (CEM) is constructed which takes into account information such as work load projections, initial and replacement equipment, expenditures, staff salaries and maintenance costs. Predictions of resource requirements for a given study period are divided into several categories for which equivalent uniform annual costs are computed. This measure of effectiveness is used for the purpose of: (i) considering the time value of money initially invested and annually incurred by each alternative; and (ii) permitting relative differences in non-uniform series of study period costs to be compared systematically on an annual basis. In essence, it is possible with the output of the CEM to quantify cost differentials among proposed radiology department designs and to study the behaviour of monetary factors perceived as relevant to the decision. Furthermore, information generated by the model permits planners to evaluate tradeoffs between investment cost and operating costs of each alternative.

719. MAKRANCZY, A. and BALAZSY, K. A járóbeteg-ellátás röntgenigényessége és ennek gazdasági kihatásai Hajdúszoboszlón. **[Demand on out-patient X-ray services in Hajdúszoboszló and its impact.]** *Egészségügyi Gazdasági Szemle*, Budapest, 1974, Dec., vol. 12, no. 4, pp. 486-498; summaries in Russian, English and German pp. 498-499.

The use of diagnostic X-ray services by out-patients in the town of Hajdúszoboszló was examined retrospectively for the year 1970/71. The number of in-patient X-rays was 100 and the number of out-patient X-rays 150 per 1,000 population; 3.7 per cent of out-patients were referred to the X-ray department and in nearly half of these X-rays were taken. Physicians who were also engaged in private practice asked for more X-rays than those who had no private practice. The average times for patients, calculated on the time of medical staff only, are misleading and should take into consideration the work of assistants. [This abstract has been prepared from an English summary of the paper.]

RADIOTHERAPY DEPARTMENT

See Abstract No. 666

DEPARTMENTS FOR SPECIAL THERAPY

See also Abstract Nos. 653, 682

720. WORLD HEALTH ORGANIZATION. REGIONAL OFFICE FOR EUROPE. **National poisons control services: report on a working group ... Lyon, 7-10 May 1974.** Copenhagen, World Health Organization Regional Office for Europe, 1974, v, 31pp.

This is the report of a working party convened to discuss the organization, responsibilities, functions and future possibilities of poisons control services. The report covers: review of the present situation; poisons control services; sources of information; recipients of services; relationships to other specialties; handling of data; laboratory services; prevention; poison centres—current trends; and the role of the World Health Organization.

721. ORRELL, F. L., BARBOUR, B. H. and BUTTS, E. S. **The role of the dialysis technician in the delivery of hemodialysis services.** *Biomaterials, Medical Devices and Artificial Organs*, New York, 1974, vol. 2, no. 1, pp. 1-19.

This paper describes a survey of the role of dialysis technicians in 10 haemodialysis units, a selected sample of all those in California. The survey used two methods: patient contact record (dialysis and non-dialysis) and task inventory. The results are presented in six tables and discussed. The results show that the increase in the availability of haemodialysis, the changes in the type of dialysis provided, and the type of facility from which the treatment is delivered have resulted in expanded roles for most types of dialysis staff, especially technicians. While some technicians still perform the traditional function of an equipment specialist, the majority are extensively and intensively involved in performing the dialysis procedure and many are responsible for delivering critical patient care.

INTENSIVE CARE UNITS

See also Abstract No. 691

722. GUENTER, C. A. **On the delivery of intensive care.** *Canadian Medical Association Journal*, Ottawa, 1975, Jan. 11, vol. 112, no. 1, pp. 55-57, 59.

Foothills Hospital, Calgary, Alta., a provincial, university-affiliated teaching hospital, has a 12-bed medical/surgical intensive care unit. During an 18-month period the unit admitted 810 patients, most of them under the care of a family physician. Quality care in the unit was maintained by the efforts of dedicated unit managers, specialists and house staff. The overall mortality in the unit of 8.1 per cent, when added to the post-unit mortality of 2.7 per cent, compares favourably with the best reported figures. Strong emphasis on selection of patients with potentially reversible disease, prompted in part by the limited facilities, may have played a part in yielding such favourable statistics. It is possible to retain participation of all members of the health care team during the brief phase of severe illness requiring intensive care.

723. POLISH HOSPITAL ASSOCIATION. Pamiętnik IV Zjazdu Naukowego, Warszawa, 15-16 Marca 1974r. Cześć I. **[Proceedings of the 4th Scientific Meeting, Warsaw, 15-16 March 1974. Part I.]** *Szpitalnictwo Polskie*, Warszawa, 1974, Sept./Oct., vol. 18, no. 5, pp. 211-322.

These proceedings include 25 papers on the organization, functions, design and equipment of intensive care units. Most of the papers have summaries in Russian and English.

724. JESSEN, K. and HAGELSTEN, J. O. **S-61 helicopter as a mobile intensive care unit.** *Aerospace Medicine*, St. Paul, Minn., 1974, Sept., vol. 45, no. 9, pp. 1071-1074.

The Sikorsky S-61 helicopter was introduced into the Royal Danish Air Force in 1966 with the principal function of undertaking search and research missions. Since then more than 1,800 missions have been carried out; 85 per cent of missions are now for civilian purposes and the service has to be considered to a wide extent as a mobile intensive care unit service. The cabin in the helicopter gives ample space for observation and treatment of the patient. The results of 190 missions are evaluated. Since vital functions cannot be monitored in the usual way in a helicopter, it was necessary to develop a dependable and safe method for continuous observation of the heart function via an electrocardiograph on an oscilloscope.

725. OLIVER, M. F., JULIAN, D. G. and BROWN, M. G. **Intensive coronary care.** Geneva, World Health Organization, 1974, 80pp.

In addition to the clinical aspects, this manual covers the organizational aspects of coronary care and the training and responsibilities of nursing staff. It should provide a firm and reliable foundation for the establishment and operation of coronary care units. The text is based on experience at the Royal Infirmary, Edinburgh, but modifications may be made to meet local conditions or to take advantage of new developments.

726. WORLD HEALTH ORGANIZATION. **Services for cardiovascular emergencies: report of a WHO Expert Committee.** (Technical Report Series, No. 562) Geneva, World Health Organization, 1975, 129pp. Sw.fr.10.

This report of a WHO Expert Committee which met in Geneva from 22 to 30 April 1974 covers: definition and magnitude of the problem; clinical aspects; organization; education; and prevention of cardiovascular emergencies. The committee made a number of recommendations on organization, preventive and clinical aspects and education, and noted areas for further study. Included among the appendices is a set of standards for cardiopulmonary resuscitation and emergency cardiac care.

727. CAMERON, M., WILKINSON, F. and HAMPTON, J. R. **Follow-up of emergency ambulance calls in Nottingham: implications for coronary ambulance service.** *British Medical Journal*, London, 1975, Feb. 15, vol. i, pp. 384-386.

Information about patients in ambulance service records has been linked to that in the patients' hospital records in an attempt to make the most efficient use of a special ambulance service for patients suspected of having heart attacks. During one week 248 emergency (999) calls for an ambulance were made by the public in the city

of Nottingham. The quality of information given to the ambulance centre was poor, and all four patients eventually found to have had a myocardial infarction were described as having collapsed. A further study of patients who were also described as having collapsed has led to a system which allows an ambulance controller to send a 'coronary ambulance' only in answer to those emergency calls where there is a reasonable possibility that the patient has had a heart attack.

728. BOEHM, F. H. **The fetal intensive care unit: an evolving concept.** *Southern Medical Journal*, Birmingham, Ala., 1974, Nov., vol. 67, no. 10, pp. 1145-1149.

The fetal intensive care unit, which has evolved in the past five years, has enabled obstetricians to be more exact in the interpretation of fetal distress and well-being. This paper describes the fetal intensive care unit at Vanderbilt University Hospital, Nashville, Tenn. Each labour room is equipped with a fetal cardiotachometer to monitor the fetus and a transducer to record maternal uterine contractions. In addition, a monitor is present in the main delivery room. All these monitors are displayed centrally at the nurses' station and doctors' lounge. Each room is equipped with oxygen as well as a Harvard infusion pump. One room is equipped for an oxytocin challenge test. Four case reports are presented to illustrate the unexpected findings that may be observed with routine continuous monitoring of the fetal heart rate.

SPECIAL HOSPITALS AND UNITS

729. CHEVALIER, J. and TAINTURIER, C. Répartition optimale des services spécialisés dans un hôpital: étudiée à partir de la classification des maladies de l'OMS. **[Optimal distribution of the specialties in a hospital: a study based on the WHO classification of diseases.]** *Hôpital à Paris*, Paris, 1974, May/June, no. 21, pp. 261-271.

During the planning of a hospital, the distribution of specialties presents difficulties because some diseases may be claimed by several specialties. This study analyses the number of patients in each specialty in a Paris hospital and their theoretical distribution in terms of the reason for admission, and tries to find a satisfactory general method for this purpose. The analysis is based on the World Health Organization (WHO) classification of diseases which is generally very useful, but it does not group diseases by specialties. The WHO list has been used as the basis of 'list S', representing 14 specialties. The main task was to collect the information concerning the principal reason for a stay in hospital, which was established on the basis of the WHO classification. The data which were obtained were reclassified according to the 'list S'. Application of this method of analysis in conjunction with the 'list S' makes it possible to classify patients according to specialties on the basis of the reason for admission. This will provide information on patients attending each hospital service and will lead to better adaptation of the hospital structure to meet the needs of patients.

OUT-PATIENT

See Abstract Nos. 719, 744, 748

CASUALTY AND ACCIDENT

See also Abstract No. 696

730. Les urgences à l'hôpital. **[Emergency patients in the hospital.]** *Hôpital à Paris*, Paris, 1974, May/June, no. 21, pp. 209-254.

A note prepared by the Paris Assistance Publique research services describes the present organization of emergency services, problems connected with their functioning, and the possibility of adapting the present structure to meet evolving needs. The quality of care is rarely criticized, but its efficiency is often questioned. There are delays in admission due to the heterogeneity and varying influx of patients, an inadequate classification and an unsatisfactory communication system resulting in transfers to other hospitals of patients requiring specialized treatment, especially in neurosurgery. Permanent interdisciplinary medical teams under one authority are desirable, but in practice this presents problems. Points raised during a discussion of the note include: (i) friendly reception of patients is most important; (ii) there should be common accommodation for medical and surgical emergencies, but separate units for out-patients; (iii) more medical staff supported by sixth-year students would be desirable; and (iv) co-operation between various specialized sectors is recommended. The exigencies of good emergency services require immediate admission, constant medical attendance, diagnostic capability and the possibility of integrating a patient into a system of care where transfers are exceptional. The present system is unsatisfactory, but it is not easy to put the remedies into practice. The best solution seems to be to organize the emergency services so that each hospital accepts responsibility for emergencies on a rota system. Finally a comparative study on medical emergency services in three Paris hospitals analyses the structure, distribution and circulation of patients, specialist treatment and the use of available facilities.

731. TUCK, J. N. **How Maryland saves lives.** *Modern Healthcare*, Chicago, 1975, Jan., vol. 3, no. 1, pp. 19-25.

This paper describes the development of emergency services in Maryland. These now include the Maryland Institute of Emergency Medicine (MIEM), Baltimore, a statewide Division of Emergency Medical Services, a helicopter ambulance service and a communication system. The MIEM treats only patients with major injuries involving at least two body systems. It now has 32 beds and more are to be added. Most admissions are brought directly from an accident by helicopter or from other hospitals. The helicopters, three of which are on duty at any one time, spend 90 per cent of their time on police work, but medical emergencies always receive priority. This helicopter system is considered less expensive than upgrading small rural hospitals.

732. HINDLE, J. F., PLEWES, L. W. and TAYLOR, R. G. **Accident and emergency services in Russia.** *British Medical Journal*, London, 1975, Feb. 22, vol. i, pp. 445-447.

On a visit to the U.S.S.R. in 1974 the authors were particularly impressed by the excellent organization for accidents and emergencies and the conspicuous absence of 'casualty departments'. In Kiev, which has a population of 2½ million, the administrative centre of the service, with the main ambulance station, is in the centre of the city; there are eight substations, all sited near a district general hospital and its

associated polyclinic. In the communications room 12 to 14 nurses answer telephone calls, arrange doctors' visits, and advise simple remedies for minor ailments. There are 125 ambulances available during the day and 86 at night; each carries a doctor, feldscher, nurse and driver. Some ambulances are manned by specialist teams who have to be called from their hospital duties. The ambulance staffs are able to follow up their patients in hospital. Since the disposal of patients is arranged by telephone there is no need for a sorting (casualty) department; patients with real emergencies are taken to the accident ward or to special departments. There are three unique features of the system: (i) the specialty has equal standing with other departments; (ii) all grades of staff feel they have an important part to play in accident prevention; and (iii) the casual attender does not present a problem as minor injuries and medical complaints are dealt with in the polyclinics.

733. HOLOHAN, A. M., NEWELL, D. J. and WALKER, J. H. **Practitioners, patients and the accident department.** *Hospital and Health Services Review*, London, 1975, March, vol. 71, no. 3, pp. 80-84.

A survey has been carried out on Tyneside on general practice and its attitude to accident care and hospital casualty departments. A questionnaire was returned by 198 general practitioners in 97 practices giving: basic practice data and arrangements for out-of-hours care; explanations of the increasing use of casualty departments; attitudes to accident care in general practice; and willingness to staff casualty departments. The following facts were revealed: (i) single-handed practitioners and partnerships of two were less likely to have appointment systems than larger practices; (ii) 55 per cent used the local deputizing service; (iii) reasons given for the increasing use of casualty departments included patients' attitudes (71 per cent), practice organization (57 per cent), general attitudes in society (23 per cent), medico-legal reasons (13 per cent) and hospital organization (12 per cent); (iv) practitioners' willingness to do minor surgery corresponded to the national average; and (v) 35 per cent of general practitioners had hospital appointments and a further 24 per cent expressed willingness to staff casualty departments.

734. ALLEN, J. R., HESKETH, Y. A. B. and NICHOLSON, H. W. **Patient documentation in an accident and emergency department.** *Hospital and Health Services Review*, London, 1975, March, vol. 71, no. 3, pp. 84-87.

Broadgreen Hospital, Liverpool, whose casualty department deals with 27,000 new cases and 25,500 return visits annually, has introduced a new system of patient documentation. The four-sheet, self-carboning form used combines the patient's treatment sheet, general practitioner's information letter, X-ray request form, and diagnostic index sheet. Basic patient information is completed and all forms are placed in a clear plastic folder for the interviewing doctor. The various sheets are completed as necessary and the folder then goes to the department secretary where the general practitioner's letter is detached. The diagnostic index sheets are detached for coding and all documents are checked. The folder is then returned to the reception area for filing or action. The system is working well.

DAY HOSPITALS

See Abstract No. 745

CHEST

735. DANDOY, S. **The use of general hospitals for tuberculosis patients.** *Public Health Reviews*, Tel Aviv, 1974, July/Sept., vol. 3, no. 3, pp. 275-300.

This paper reviews the literature, largely from the United States, on the role which the general hospital has assumed in the last 10 years in the treatment of tuberculosis patients. It covers: historical aspects; factors permitting the use of general hospitals; trends toward general hospital use; requirements for general hospitals; planning decisions; opposition; criteria for admission; criteria for discharge; costs; future use of tuberculosis hospitals; and future perspectives. A list of 67 references to the literature is included.

INFECTIOUS DISEASES AND ISOLATION

See Abstract Nos. 615, 688

CHILDREN

See also Abstract No. 750

736. SHERIDAN, M. S. **Talk time for hospitalized children.** *Social Work*, New York, 1975, Jan., vol. 20, no. 1, pp. 40-47.

In February 1972 the departments of nursing and child psychiatry of the University of Illinois Hospital, Chicago, initiated a programme called 'talk time' for child patients. The social worker assigned to the in-patient paediatric service became active in the programme at the end of its first year and receives support from other members of the department. The programme focuses on discussion and encourages children to share their fears and fantasies of the hospital experience. This paper discusses the theoretical basis and practical applications of 'talk time' from the social work point of view.

737. PACHE, H-D. Zur Mitaufnahme von Müttern in westdeutschen Kinderkrankenhäusern. **[Admission of mothers to West German children's hospitals.]** *Krankenhaus*, Stuttgart, 1975, Jan., vol. 67, no. 1, pp. 26-30.

A questionnaire on the admission of mothers with their children was completed by 151 children's hospitals or children's departments in Western Germany. Ninety-seven said that, for various reasons including lack of space, such admissions were not possible. While 54 said that mothers were admitted, in 35 of them not more than 10 such admissions were made annually. In 16 hospitals with 'effective' admission of mothers the percentage was 1.2 per cent while the overall average was only 0.5 per cent. The following criticisms were made of a joint admission policy: presence of the mother inhibits contact between the child and the doctor and nurse; the work of the ward is disturbed; 24 hours a day at the bedside is often too much for the mother; the high cost of such admissions is not justified; the separation of mother and child is often itself part of the treatment; such admissions are in many cases made out of regard for the mother rather than the child; and usually it is only mothers in the upper social classes with only one child and who do not work who wish to be so

admitted. Alternatives to the admission of mothers would be for the mother to spend the whole day at the hospital but to go home for the night, or daily visiting for limited periods (this was done in 95 of the hospitals answering the questionnaire). The author concludes that the separation of the child from its mother during a stay in hospital is less serious than that resulting from the full-time employment of mothers of pre-school children.

GERIATRICS AND LONG-STAY

See also Abstract Nos. 622, 630-632, 698

738. MICO, P. R. **Some dynamics of change in the organization and management of physician services in long term care facilities.** *Journal of Long Term Care Administration*, Silver Spring, Md., 1974/75, vol. 3, no. 1, pp. 9-18.

This paper discusses changes which are taking place in the role and control of long-stay care facilities in the United States and the effect of these changes on the organization and management of medical staff services. Also discussed are a number of concepts regarding organizational change which are applicable. The implications are summarized as follows: (i) the first priority is a clear understanding of the mission or function of the facility; (ii) the structure or form of the organization should be designed to facilitate the carrying out of the mission; (iii) effective line-management relationships must be established; and (iv) it is very important that high priority be given to the conditions or rules which govern how staff members work together.

739. HOWARD, J. B. and STRONG, K. E. **The nursing home medical director and quality care.** *Journal of Long Term Care Administration*, Silver Spring, Md., 1974/75, vol. 3, no. 1, pp. 3-8.

Most studies of medical care in long-stay facilities have shown that its quality is not as good as it could be. This paper discusses the functions of the medical director in improving this situation. These include: (i) ensuring open channels of communication with patients, nursing and administrative staff, and attending physicians; (ii) holding periodic rounds; (iii) establishing policies on procedures and documentation; (iv) providing nursing staff education; and (v) reviewing medication order sheets.

740. TESSARO, E. A. **The medical directorship.** *Journal of Long Term Care Administration*, Silver Spring, Md., 1974/75, vol. 3, no. 1, pp. 19-59.

Long-stay facilities in the United States providing skilled nursing care are now required to have medical direction. In this paper a lawyer discusses: (i) the nature of the medical directorship; (ii) its source of authority and administrative responsibility; (iii) its legal responsibilities; and (iv) how the directorship may be put into effect.

741. BARKER, J. **Hospital and community care for the elderly.** (Manifesto Series No. 27—Specialist Report) Mitcham, Age Concern, 1974, 24pp. £0.20

The report is one of a series providing background material for a manifesto on the place of the retired and elderly in modern society. It presents a number of facts, beliefs and hypotheses on the problem of the health care of the elderly, its background,

quantity and distribution of resources, communication, professional attitudes, problems created by the hospital, and reticence about seeking help and complaining.

742. BRICKNER, P. W. and others. **The homebound aged: a medically unreached group.** *Annals of Internal Medicine*, Philadelphia, 1975, Jan., vol. 82, no. 1, pp. 1-6.

The authors identify the scope of health problems of elderly housebound people, describe an effective method of health care they have devised to meet their needs, and discuss the results of the first 16 months of the programme and its implications. The programme, called the Chelsea-Village Program started in January 1973 to meet the health and associated needs of house-bound isolated people in the Chelsea and Greenwich Villages areas of Manhattan, surrounding St. Vincent's Hospital. The aim is to keep patients in their own community, in adequate housing, out of institutions and as well and independent as possible. Local organizations and residents serve as case finders and doctors, nurses and social workers from St. Vincent's Hospital provide a wide range of services in patients' homes. During the first 16 months, 200 people (131 women and 69 men) were referred and 620 home visits were made. The oldest patient was 105 and the youngest 24; the average age is 80. Although the scheme is primarily for the aged, younger housebound and isolated people are also served. Eight per cent of patients are under 60. Tables in the text illustrate the ages of patients, sources of referral, causes disability and present status of patients. The programme effects considerable financial savings compared to hospital care and in general the elderly patients prefer being cared for at home.

743. RUNYAN, J. W. **The Memphis chronic disease program: comparisons in outcome and the nurse's extended role.** *Journal of the American Medical Association*, Chicago, 1975, Jan. 20, vol. 231, no. 3, pp. 264-267.

The programme in Memphis and Shelby County, Tennessee, for the continuing care of patients with certain chronic diseases now has over 9,000 patients under regular care. This paper is concerned primarily with making certain comparisons between patients receiving care in decentralized facilities staffed by specially trained nurses and those receiving care in a more conventional manner in the out-patient clinics of the City of Memphis Hospital. The patients, clinic settings and statistical methods are described. The results are presented in six tables and discussed; they give further support to the concept introduced nearly 12 years ago that nurses can effectively share a large and increasing responsibility in the care of the chronic sick.

744. FORRESTER, R. H. and HILL, C. L. **Improving care of the chronically ill.** *Hospitals*, Chicago, 1975, Jan., 16, vol. 49, no. 2, pp. 57-62.

In 1970 a demonstration clinic was established in the out-patient department of Robert B. Green Hospital, San Antonio, Tex., to provide follow-up care for certain chronically ill patients. The follow-up care of such patients is sufficiently stereotyped that it can be taught to a licensed vocational nurse, who is called a medical assistant in this project. After a period of on-the-job training by a physician, the medical assistant conducts the follow-up visits of the patients. This paper describes the development of the clinic, the intake and enrolment of patients, the procedure for follow-up care, the roles of the physician and the medical assistant and the format of the medical record.

745. LORENZE, E. J., HAMILL, C. M. and OLIVER, R. C. **The day hospital: an alternative to institutional care.** *Journal of the American Geriatrics Society*, Baltimore, 1974, July, vol. 22, no. 7, pp. 316-320.

This paper describes the objectives and admission criteria of day hospitals for patients with physical disability or chronic illness as distinct from those with primary psychiatric illness. The day hospital, as part of a general hospital complex, provides health care and supportive services during the day for accepted patients, who return home at night. The new day hospital of the Burke Rehabilitation Center, White Plains, N.Y., is open from 0830 to 1730, Monday to Friday and provides a broad range of services. Transport is provided within a five-mile radius. The criteria for acceptance are listed and the intake process is outlined. The hospital's research programme is outlined; it aims to obtain extensive data on admission criteria, cost of service and resulting benefits.

CARDIOLOGY

See Abstract Nos. 725-727

UROLOGY

See Abstract Nos. 682, 721

SURGERY

See also Abstract No. 662

746. WILKEN, B. J. **Patterns of general practitioner referral to a surgical unit.** *Hospital and Health Services Review*, London, 1975, Feb., vol. 71, no. 2, pp. 46-48.

A review of out-patient referrals to the Professorial Surgical Unit was made at Southampton University Medical School. This unit functions as a general surgical unit, receiving both emergency and elective patients and having oncology (breast cancer in particular), gastroenterology and endocrine surgery as special interests. A pilot study confirmed that the new patient rate was high, 644 new patients being referred during March to June 1973. Of these, 213 were referred to the breast clinic, 82 to a small peripheral clinic and the rest to general clinics in the main hospital. Further study was made of these patients during September to December 1973 and January to April 1974 with the aim of identifying patterns of referral in relation to services offered by the unit. All referrals were categorized by referring doctor, area and type of conditions. The results are discussed in the paper and several tables of figures are given. The number of patients referred during each three-month period was very constant. Just over two-fifths of all patients (42 per cent) were in a main interest of the unit—gastroenterology; 27 per cent consisted of routine problems such as hernias and varicose veins; and 27.5 per cent were miscellaneous conditions such as sebaceous cysts, small lipomata and minor skin blemishes which could mainly be dealt with by house surgeons in an out-patient theatre. The remaining patients (3.5 per cent) were referred with thyroid or salivary gland lesions. The principal indication for referral appears to be practitioner preference.

747. PRSALA, H. **Admission unit dispels fear of surgery.** *Canadian Nurse*, Ottawa, 1974, Dec., vol. 70, no. 12, pp. 24-26.

The admission unit at Halifax (N.S.) Infirmary admits only patients scheduled for elective surgery; one of its planned activities is pre-operative teaching to reduce a patient's anxiety and promote his co-operation and post-operative recovery. The unit is in a bright sunny location on the seventh floor of the hospital. It accommodates 26 patients, but the daily average is 18; the stay in the unit is usually four to five hours. The unit is staffed by two registered nurses, a certificated nursing assistant and a ward clerk and is open from 0800 to 1600; no patients are kept overnight.

748. REED, W. A. and FORD, J.L. **The Surgicenter: an ambulatory surgical facility.** *Clinical Obstetrics and Gynecology*, New York, 1974, Sept., vol. 17, no. 3, pp. 217-230.

On the basis of experience at the Surgicenter, Phoenix, Ariz., [see *Hospital Abstracts*, Vol. 10, Abstract 1252], the authors discuss the following aspects of out-patient surgery: problems in initiation; benefits to the surgeon; essentials for patient safety; and benefits to patients. Procedure at the Surgicenter is described. The majority of operations performed at the Surgicenter are gynaecological; some details of these are given and the procedure for discharge of gynaecological patients is outlined.

MATERNITY

See Abstract No. 728

GYNAECOLOGY

See Abstract No. 748

PSYCHIATRY

See also Abstract Nos. 654, 684, 698

749. JONES, M. B. and SYLVESTER, P. E. **Profiting from experience: fresh thoughts on a mixed unit for children and adults.** *Apex*, Kidderminster, 1974, Dec., vol. 2, no. 3, pp. 4-7.

For the past four years, St. Lawrence's Hospital, Caterham, has operated successfully a unit known as Greenacres, in which mentally handicapped men, women and children have lived together [see *Hospital Abstracts*, Vol. 12, Abstract 292]. In spite of its success the venture does not represent the ultimate in long-stay care. This paper presents a number of points which seem important to improve upon in a new unit for the deaf which is being planned. They cover: (i) involvement of residents during the conversion of the accommodation; (ii) involvement of staff; (iii) the problems of aging; (iv) selection of residents; and (v) general considerations. Lessons learned from Greenacres which will be applied to the unit are: (i) the need for more privacy; (ii)

pre-unit training for the resident group; (iii) pre-unit training for the staff; (iv) choosing a wider age-range of residents and not necessarily excluding those who have behaviour problems; and (v) using the unit as a stage in preparing for life in the community.

750. ERLER, H. and others, editors. Das stationäre und ambulante Gesundheitswesen: Planung, Organisation, Bau und Betrieb. Band 22. Psychiatrische Betreuungseinrichtungen. **[The planning, organization, building and administration of in- and out-patient facilities. Vol. 22. Psychiatric facilities.]** Berlin, Verlag Volk und Gesundheit, 1974, 136pp.

This 22nd volume in a series dealing with health service facilities in Eastern Germany consists of 14 papers dealing with the care of mentally handicapped and psychiatric patients. These cover the general network of services throughout the country, including sheltered residences and workshops, day hospitals, and psychiatric in-patient facilities. There are also papers on the design of psychiatric hospitals, on the planning and organization of child guidance clinics, and on district psychiatric services. Also included is a description (with 22 photographs and plans of each floor) of the children's hospital opened at Görlitz in July 1972 [apparently a general, not a psychiatric, hospital]. This has a four-storey ward block with two- to four-bed patients' rooms on a single corridor plan and a single-storey infectious diseases and observation block. The total number of beds is 180.

751. BARTOSZEWSKI, J. A. Rozwoj oddziałow psychiatrycznych w szpitalach ogólnych na ziemiach Polskich na tle rozwoju tego rodzaju oddziałow w innych krajach. **[The development of psychiatric departments in general hospitals in Poland compared with similar developments in other countries.]** *Szpitalnictwo Polskie*, Warszawa, 1974, July/Aug., vol. 18, no. 4, pp. 165-169; summaries in Russian and English p. 169.

The development of psychiatric departments in general hospitals is outlined from its very beginning in 875 in Arabic medicine through the 18th and 19th centuries in the U.S.A., Austria and Germany to the present time. Similarly in Poland psychiatric departments have been developing since the 18th century. Before the Second World War the prevailing tendency towards the treatment of patients in psychiatric hospitals inhibited the development of psychiatric departments as opposed to the adopted policy in other countries. Post-war difficulties and mistaken theories of psychiatric treatment led to continued neglect of the development of psychiatric departments while in other countries many such departments were opening. Since 1960 the role of the psychiatric department has been stressed and several new departments have been opened; in 1970 2.6 per cent of psychiatric beds were in general hospitals. In spite of recent plans for more psychiatric departments, there is still insufficient research in this field.

752. SMITH, S. L. and ENGLISH, J. **The training and role of nurse-therapists in a general hospital's psychiatric unit.** *Hospital & Community Psychiatry*, Washington, 1975, Jan., vol. 26, no. 1, pp. 21-24.

The psychiatric in-patient unit of St. Joseph's Hospital, Hamilton, Ont., began to train nurses as therapists in 1968. The unit has 14 beds and the average length of stay

is 13 days. Nurse-therapists perform regular nursing duties and in addition have specific therapeutic tasks including taking complete case histories, recommending special tests and making a diagnosis. The programme began with the intensive training of four nurses, experienced in clinical but not psychiatric treatment, under the supervision of the unit's resident psychiatrist. Four other nurses were then assigned after a few months to work as their assistants. The training has continued in this way to three levels with senior nurse-therapists instructing newer recruits. Each patient is assigned a senior and junior therapist. Some problems have arisen both amongst medical staff and patients in accepting the new therapists, of whom there are now seven. The large amount of time devoted by psychiatric and other senior staff to training the therapists also caused problems, but this has been reduced gradually as the programme has become well established. The nurses' additional work has meant a necessary reduction in traditional duties, so patients are encouraged to help with these. It is felt that therapists would be unsuitable for an out-patient unit, whereas they provide valuable supervision in a small in-patient unit, and reduce the need for more than one resident psychiatrist. Also a higher therapeutic staff/patient ratio is produced, enabling important decisions to be made at once, without necessary reference to the psychiatrist. A follow-up study in 1972 showed that patient care had in no way diminished since the introduction of the programme.

753. MAISEY, M. A. **Hospital-based psychiatric nurse in the community.** *Nursing Times*, London, 1975, Feb. 27, vol. 71, no. 9, pp. 354-355.

This paper reports a three-month survey of the ways in which a group of hospital-based psychiatric nurses participated in the care of their patients outside the hospital. During the three months a total of 139 hours was spent in the community, an average of 10.7 hours per week or only one-quarter of one full-time working week. No decrease in the standards of in-patient care as a result of extra-mural activities was discernible. The value of the hospital-based psychiatric nurse involved in the community is discussed.

754. MILLER, K. S., SIMONS, R. L. and FEIN, S. B. **Compulsory mental hospitalization in England and Wales.** *Journal of Health and Social Behavior*, Washington, 1974, June, vol. 15, no. 2, pp. 151-156.

Compulsory admissions to psychiatric hospitals in England and Wales from 1964 to 1970 are analysed in terms of variations over time, region, age, sex, and first or multiple admissions. The analysis shows that the use of compulsory admission is highly variable; this variability occurs not only between regions for any given year, but also within regions across time. There were no major administrative, legal, economic or political changes which might explain the variability. Since there is no reason to believe that the distribution of behaviours or symptoms, or of alternative services, follows or administrative policy rather than the needs of the patient. It is clear that there has been a definite failure to reach the goal of less than five per cent of formal admissions envisaged by the Royal Commission on Mental Health. The authors believe that malicious compulsory admission is rare, but that compulsion is used much more frequently than is necessary and that it is arbitrarily used. An argument is made for a critical review of the use of compulsory powers.

755. LEWIS, T. **The patient is responsible.** *Nursing Times*, London, 1975, March 13, vol. 71, no. 11, pp. 434-435.

Although only a comparatively small number of psychiatric patients are admitted to hospital compulsorily, few arrive at or remain in hospital voluntarily. In the author's experience most voluntary patients are in fact sent to hospital. Once there the patient not free to make many personal decisions; this robs him of an aid to his recovery. In an acute admission ward at Whitchurch Hospital, Cardiff, the nursing staff began to question and examine their traditional roles. As a result patients are now allowed to make some personal decisions in discussion with the nursing staff. The ward has since been used as a learning situation for an introductory course in the practical application of social psychiatry.

756. VOINESKOS, G. and others. **Self-care program for inpatients in a mental hospital.** *Canadian Medical Association Journal*, Ottawa, 1975, Jan. 25, vol. 112, no. 2, pp. 177-180.

This paper describes the development and first year of operation of a self-care programme for selected patients in a psychiatric hospital. The 12-bed unit operates without any nursing or other professional staff from 2000 to 0800 each weekday and throughout the week-end. During this time a university student designated as house adviser is on the ward; sometimes after 2300 he goes to bed. The paper covers: the setting, the programme and the house advisers; criteria and contract of entry to the programme; the patients; processes involved in the development of the programme; and the results. Certain factors, including the psychiatric hospital as an organization, tend to hamper the development of this type of programme as well as the progress and growth of other programmes in psychiatric hospitals. It is suggested that the much needed progress in the psychiatric hospital would be facilitated by an open-system approach to its organization. Psychiatric hospitals should consider the introduction of self-care programmes for selected patients, mainly in view of their therapeutic potential, but also because of the financial savings such programmes offer.

757. KATZ, R. C. and WOOLLEY, F. R. **Criteria for releasing patients from psychiatric hospitals.** *Hospital & Community Psychiatry*, Washington, 1975, Jan., vol. 26, no. 1, pp. 33-36.

A standard set of criteria which can be used to determine the effectiveness of psychiatric treatment in the long term has yet to be developed. Some authorities equate effectiveness with parameters of hospital release, while others consider the subsequent functioning of former patients in the community a more important guide. Hospitals vary considerably in determining appropriate grounds for releasing patients, and to test this a pilot study was carried out in 1973 involving 10 psychiatric hospitals in the western United States. Forty-two staff in these hospitals, including doctors, clinical psychologists and psychiatric social workers, were asked to rate the importance of 21 hypothetical criteria for determining the release of a patient. There was general agreement that the most important criteria should include: (i) whether the patient functions in an acceptable manner, and is no longer harmful to himself and others; and (ii) behaviour improvement is strong enough to be maintained outside the hospital. Less important criteria included: (i) the request to be discharged is against medical advice; and (ii) the patient has absconded repeatedly whilst in hospital.

However, there were significant differences of opinion over some criteria, and this was attributed mainly to whether or not the hospital was affiliated to the Veterans Administration. A list of discharge criteria similar to the one presented could in most hospitals be a useful tool in determining whether to discharge a patient.

758. BROOK, P. and COOPER, B. **Community mental health care: primary team and specialist services.** *Journal of the Royal College of General Practitioners*, Edinburgh, 1975, Feb., vol. 25, no. 151, pp. 93-98, 103-110.

This paper reviews the roles of primary care and specialist teams in the field of mental health and tries to fit their contributions into an effective model of community psychiatry. It is concluded that closer working links must be established between the specialist services and primary care teams in order to promote community mental health care. Psychiatrists should maintain direct contact with primary care teams in their sectors and a proportion of psychiatric nurses should be seconded to community work on a full-time or part-time basis with direct contact with primary care teams. A number of research needs are indicated. A list of 95 references to the literature is included.

SOCIAL MEDICINE

759. FULFORD, R. C. and ROBERTS, N. G. **Hospital-university student health service.** *Hospitals*, Chicago, 1975, Jan. 16, vol. 49, no. 2, pp. 52-54.

Baptist Hospital, Pensacola, has provided a health service for the students of the University of West Florida since 1967. This paper outlines the development of the service, which is based on the student health centre. The centre is organized as a department of the hospital's division of nursing service and is supervised by a registered nurse who reports directly to the hospital's nursing director. The centre is staffed by registered nurses 24 hours a day, seven days a week. Each staff nurse assigned to the centre must also be a full-time student completing a degree course. The present centre includes a holding room, office, small bedroom for the night nurse and a four-bed ward, which can be expanded by two beds. The centre provides limited medications, first aid supplies and physiotherapy. A contract physician, not connected with the hospital, conducts a clinic on each class day. Maintenance of the building is the responsibility of the university; equipment and furniture maintenance is the responsibility of the hospital.

760. LEWIS, H. L. **Methodist of Indiana: a pioneer in preventive medicine.** *Modern Healthcare*, Chicago, 1974, Dec., vol. 2, no. 6, pp. 21-26.

For more than a decade the medical staff of the 1,074-bed Methodist Hospital of Indiana, Indianapolis, have been developing the practice of prospective medicine, the reverse of retrospective medicine or the treatment of end stages of disease. A key element is a statistical analysis system called Health Hazard Appraisal (HHA), which may become the cornerstone of health education programmes of the future. Through HHA, doctors can devise a graphic plan for moving their patients through life one decade at a time. They do this by helping their patients deal with known risks, precursors of disease, by urging changes in life style. The graphic plan is based on risks tables. This paper describes the development and application of HHA and discusses some constraints on its wider use.

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Technische Gids voor Ziekenhuis en Instelling, Tesselschadestraat 18-22, Amsterdam, Netherlands. fl.5.50.
Trustee, 840 North Lake Shore Drive, Chicago, Ill. 60611, U.S.A. $0.75.
Ziekenhuis, Nationale Ziekenhuisraad, Oudlaan 4, Utrecht, Netherlands. fl.3.00.

PUBLISHERS

Age Concern, 60 Pitcairn Rd., Mitcham, Surrey CR4 3LL, England.
American Hospital Association, 840 North Lake Shore Drive, Chicago, Ill. 60611, U.S.A.
Association of University Programs in Health Administration, Suite 420, One Dupont Circle, Washington, D.C. 20036, U.S.A.
Health Administration Press, M2210 School of Public Health, University of Michigan, Ann Arbor, Mich. 48104, U.S.A.
Hospital Research and Educational Trust, 840 North Lake Shore Drive, Chicago, Ill. 60611, U.S.A.
Lea & Febiger, 600 South Washington Sq., Philadelphia, Pa. 19105, U.S.A.
Mosby, 3207 Washington Blvd., Saint Louis, Mo. 63103, U.S.A.
Open University Press, Walton Hall, Milton Keynes, Bucks. MK7 6AB, England.
University Park Press, Chamber of Commerce Building, Baltimore, Md. 21202, U.S.A.
Verlag Volk und Gesundheit, Berlin, Germany.
World Health Organization, Avenue Appia, Geneva, Switzerland.
World Health Organization, Regional Office for Europe, 8 Scherfigsvej, DK-2100 Copenhagen Ø, Denmark.

Printed in England for Her Majesty's Stationery Office by Holmes & Sons (Printers) Ltd., Andover, Hampshire.
Dd. 506836 K11 6/75 7916

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ISBN 0 11 722485 5